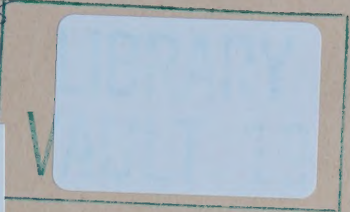


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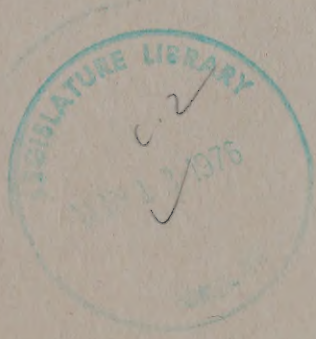


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Quarterly Statistical Review



Alberta

SOCIAL SERVICES AND
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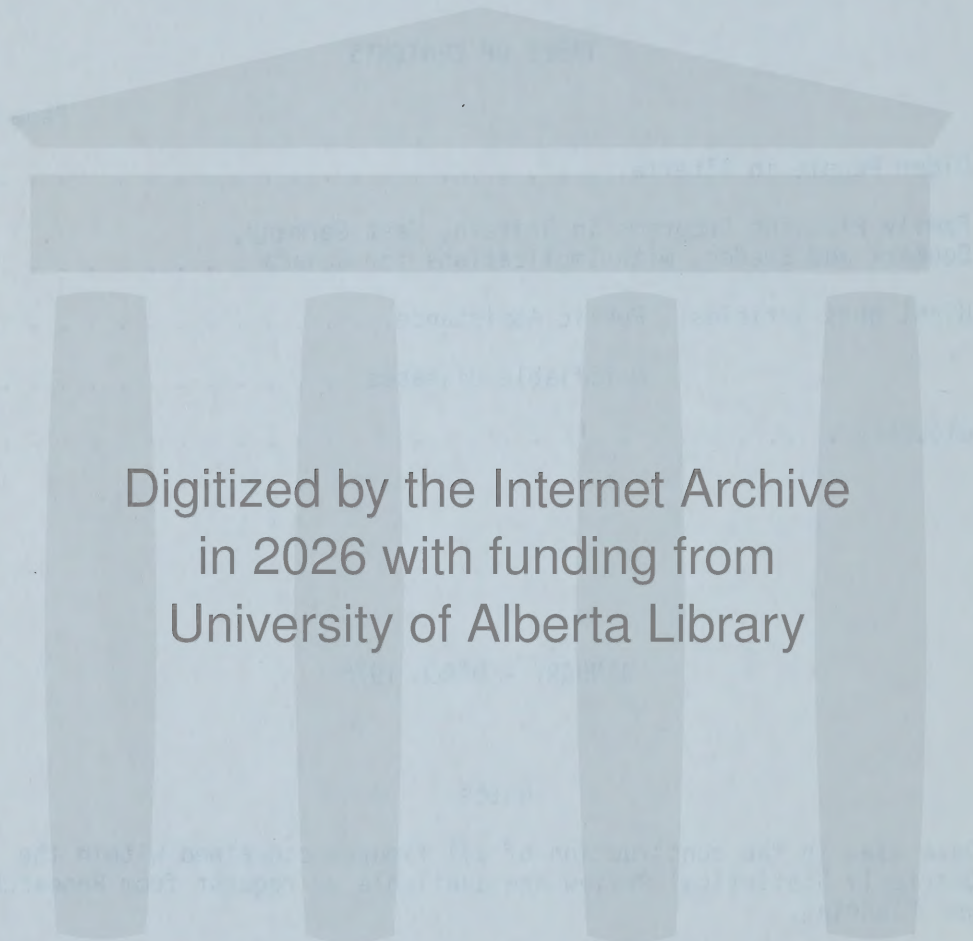
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JANUARY - MARCH 1975

Notes:

Data used in the construction of all figures contained within the Quarterly Statistical Review are available on request from Research and Planning.

Highlights of child welfare statistics are not included in this issue because of a five-month interruption in the operation of the child welfare statistical system. The monthly output from this system was halted in November, 1974, as a consequence of efforts to modify the basic table programs so that they would provide more accurate and relevant information. The operation of the system is scheduled to resume at the end of April, 1975. If this occurs, highlights of child welfare statistics will appear in the next issue of the Review.



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OLDER PEOPLE IN ALBERTA

Catherine Cornell and Mary Engelmann*

Alberta has historically been a relatively "young" province and remains so today. But the number of persons 65 years of age and over¹ has rapidly increased over the past few decades, and their proportion in the total population has risen substantially. This phenomenon of "aging of the population" is occurring throughout Canada and the rest of the industrialized world.

Survival to old age in contemporary industrialized societies often involves a loss of health and income, loss of a spouse, and loss of friends and acquaintances. The elderly are increasingly finding themselves dependent upon government financial support or institutional care. Because more people are living to old age, the problems that they face are an issue of major public concern -- particularly for agencies in the area of health and social services.

The purpose of this three-part article is to present a profile of Alberta's elderly -- their demographic and socio-economic characteristics, their needs for health and social services, and their present utilization of selected services. In the past, it has been difficult to maintain a comprehensive view of the elderly in Alberta because the data have been widely scattered throughout various agencies. It is hoped that this article, while not presenting any new data, will be useful in integrating data from a number of sources.

Part One of this article will deal with the demographic and socio-economic characteristics of Alberta's senior citizens. Part Two will review studies of senior citizens' needs for health and social services, and Part Three will look at present utilization of services by older people in our province.

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¹This article will focus on the demographic characteristics and health and social service needs of people 65 years of age and over in Alberta. The terms "senior citizens, the elderly, older persons, and the aged" will be used interchangeably to designate this age group.

PART ONE -- DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS

The "age" of a country can be described in terms of the percentage of its population which is 65 years of age and over. Canada has a relatively young population in comparison with other industrialized countries in the world, as only eight per cent of its citizens fall into this group. Most western European countries have an elderly population of 12 to 15 per cent. In contrast to Canada, the developing countries in Asia, Africa and South America are "young" with only three to four per cent of their populations being 65 and over (see Table 1).

On the Canadian scene, only Quebec, Newfoundland and the Northwest Territories have a smaller percentage of older people than Alberta (Table 2). In spite of an absolute increase in the numbers of elderly persons in this province, the percentage that they constitute of Alberta's population is still not large. This is primarily due to significant in-migration of younger persons seeking employment opportunities, particularly since World War II. Current migration into Alberta remains high.

How many senior citizens does Alberta have? Table 3 shows the actual population of Alberta from 1901 to 1971 as well as the projected population to 2001 with the number and percentage of people 65 years and over, and 85 years and over. Data on the age group 85 years and over are included because it has been determined that there are significant variations between the needs and concerns of the "young old" and the "old old".

Alberta is gradually "aging". While in 1901 only 1.9 per cent of the population was 65 and over, by 1971 this had risen to 7.3 per cent, and by 2001 over 10 per cent of our population will be senior citizens. The corresponding percentages for the 85 and over group are 0.1, 0.6 and 1.1 per cent.

Table 4 illustrates the variation in growth rates of different age groups in the Alberta population between 1951 and 2001.² The percentage growth rate of the 0-14 age group is the lowest at 120.8 per cent during this 50 year period while the percentage growth rate of those 65 and over will be 295.5 per cent and for those 85 years of age and over, 1052.4 per cent. However, the magnitude of this increase is partially a statistical product of the small 1951 population

²The percentage growth rate was calculated by expressing the growth in absolute numbers as a percentage of the 1951 population.

base in the older age groups; there were only 2,421 persons 85 years of age or older in 1951. Perhaps a more important statistic is that, in 1951, persons 85 and over comprised 3.6 per cent of the senior citizen population; by 1971, 8.6 per cent; and by 2001, 10.5 per cent. This increasing proportion of the elderly has significance for the development of programs. Figure 1 illustrates the changing proportions of the Alberta population among four broad age groups: 0-14, 15-44, 45-64, and 65 and over. The great increases in the two elder age groups are clearly evident.

An "age-sex pyramid" is a common graphic technique which shows the percentage of the total population falling into each age-sex category. Figure 2 superimposes the projected Alberta age-sex pyramid for the year 2001 over the actual pyramid for 1901. The Alberta population is in the process of changing from a short broad-based pyramid to a taller, but narrower-based pyramid, illustrating the dramatic aging of the population.

Within Alberta there are regional variations in the age structure. In general, southern and east-central Alberta are "older" areas, while northern and western areas tend to be "younger". Table 5 presents sub-provincial data on the population 65 years of age and over in 1971 for health units, social development services regions, mental health regions, and all population centers of 1000 population or more.

As shown in Table 6, the elderly in Alberta are not distributed evenly through rural and urban areas, but rather the highest concentrations of elderly are in small towns (1000 - 5000 population) and rural non-farm areas (i.e., centers of under 1000 population). Lethbridge (the only city in the 30,000 - 99,999 urban population category), and Medicine Hat (population 26,518) were exceptions with 10.7 per cent and 12.3 per cent respectively of their 1971 population in the senior citizens group.

In the recent past (1961 - 1971), this concentration of the elderly in the smaller Alberta centers has become even greater. For example, in 1961, 8.1 per cent of the population living in towns between 2,500 and 4,999 population were senior citizens. By 1971, this percentage had increased to 11.1 per cent.³ In contrast, the percentage of the elderly farm population decreased during the same 10 year period from 18.6 to 10.4 per cent. This concentration of elderly persons in small towns has been due to two factors: (a) in-migration of elderly persons from the surrounding rural areas, and (b) out-migration of

³As a reference point, the percentage of all senior citizens in Alberta only increased from 6.98 to 7.3 per cent during the same 10 year period.

young persons (e.g., 15-25 years) to the larger cities for employment and/or education. The larger cities have experienced a significant in-migration of young people from outside the province which reduces the proportion of the elderly.

Looking only at the "old old" (persons 85 years of age and over), there has been a shift away from the farm to the rural non-farm, and in general from rural (population under 1000) to urban (population over 1000). In 1961, 30.7 per cent of those 85 and over lived in rural non-farm and farm areas and 69.3 per cent in urban areas. In 1971 this had shifted to 18.3 per cent for rural and 81.7 per cent for urban. The highest concentration of the "old old" is found in communities between 1000 and 10,000 population.

Published 1971 census-data do not deal specifically with the volume of rural/urban flows for the population 65 years and over. However, the data that are available allow some approximation of these flows. Table 7 shows that, generally, elderly persons tend to be far less migratory than other age groups, particularly the 15-44 age group. Urban and rural non-farm populations are more transitory than rural populations. Very few in-migrants from other provinces, or immigrants from outside Canada, are 65 years or older.

A common statistical technique for comparing the relative "ages" of the population of different areas (whether they be countries, provinces, regions, or towns) is known as the "dependency ratio". Three types of dependency ratios are employed:

- (1) the young dependency ratio -- the number of persons aged 0-14 years per 100 persons of productive age (usually defined as 15-64 years).
- (2) the old dependency ratio -- the number of persons aged 65 years or older per 100 persons of productive age.
- (3) the total dependency ratio -- a composite ratio of the number of persons 0-14 years, plus the number of senior citizens, per 100 persons of productive age.

The concept of a dependency ratio is based on the arbitrary division of the population into "dependent" and "productive" categories on the basis of age alone without allowing for those in the 15-64 age group who are dependent on society for their maintenance, or for the senior citizen group who are in the labor force or do have savings (factors which make them economically independent). These ratios provide a gross estimate of the proportion of persons who, because of their age, are economically dependent upon the productive population. Thus, a high young dependency ratio would indicate the need for

a greater proportion of total expenditures on education, day care, and child health programs. A high old dependency ratio would indicate the need for a greater proportion of total expenditures on income security programs, and health and social services for the aged.

Figure 3 illustrates the changes in the three dependency ratios in Alberta for the century 1901 - 2001. The young dependency ratio historically has fluctuated in Alberta because of variation in the birth rate (e.g., the effect of the "baby boom") but the ratio has declined in the recent past and is expected to decline further in the future. In contrast, the old dependency ratio has steadily increased in the past and this trend will continue in the future. The total ratio shows an overall decline (except during the baby boom) as the decrease in the young ratio more than offsets the increase in the old ratio. This indicates that more consideration will have to be given to services for the elderly - either by reallocation of society's productivity through the taxation system, improved pension plans, or some other means - if the elderly are to even maintain their relative economic position in society.

Figure 4 illustrates a corresponding variation in dependency ratios to rural/urban variation of the population 65 years and over. In 1971, the highest old dependency ratios were for towns of under 5,000 population and the lowest old dependency ratio was for the rural farm category. This again indicates that the elderly are migrating from farm areas into nearby towns to be near their friends and relatives, and to stores and services.

Are people continuing to work after retirement? Table 8 presents the labor force participation rates⁴ by sex and rural/urban categories for the population 65 years and over in Alberta (1971 Census of Canada). Thirteen per cent of the elderly in urban areas were employed in 1971, 14.6 per cent of the rural non-farm elderly, and 49.1 per cent of the farm elderly. In comparison with the total Canadian elderly population, Alberta labor force participation rates were lower in urban areas, but higher in rural non-farm and farm areas. One trend which may be important for future planning is the increasing tendency for women in the age group 15-64 to be employed. Both the young and the old may be losing an important source of care that may increasingly have to be supplied by persons other than mothers and daughters.

⁴The labor force participation rate is the percentage of the total population in that age group included in the labor market. Please refer to footnote b on Table 9 for further explanation.

Another index of economic dependency is the average total income.⁵ As shown in Figure 5, over 63 per cent of Alberta males 65 years and older, and over 84 per cent of Alberta females, reported in the 1971 Census a total annual income of less than \$3,000. This compares to 32.8 per cent for males aged 15-64 and 74.7 for females. Only 5.3 per cent of males aged 65 and over, and 1.2 per cent of females, had a total income of \$10,000 or more. The average income for all males 65 years and over was \$3,639 and for females was \$2,059. This compares to \$6,210 for males aged 15-64 years, and \$1,722 for females aged 15-64.⁶ However, it must be remembered that a substantial portion of the income received by the elderly is Old Age Security and Guaranteed Income Supplement payments - income support programs of the federal government. Data on these programs will be provided in Part Three of this article. Given the low income of most elderly persons, partial or complete subsidization of government health and social services would seem to be necessary.

Women have a longer average life expectancy at birth than men. For both Alberta and Canada, the 1971 female life expectancy was seven years beyond male life expectancy (see Table 9). During this century, life expectancy for both sexes has increased, mostly from the substantial decline in the infant mortality rate. This is illustrated in Table 9 by the decreasing gap between life expectancy at birth and at one year. The rate of increase in life expectancy has now apparently reached a plateau stage, particularly for males (see Figure 6).

How does the number of elderly men compare to women? The "sex ratios"⁷ of males and females 65 years of age and over, and 85 years of age and over, between 1901 and 1971, with projections to 2001 are shown in Table 10 and Figure 7. The effect of the "frontier era" can still be seen in Alberta for as recently as 1971 there were still slightly more elderly men than women. The high proportion of single males (as well as families) migrating to Alberta in the early 1900's are still with us. However, the projections indicate that the sex ratio will rapidly change. By 2001 there will be 739 males per 1000 females aged 65 years and over, and only 429 males per 1000 females aged 85 years and over. This increasing predominance of females among the elderly must be reflected in the types of programs and facilities provided for the elderly in the future.

⁵Total income includes income from all sources (please refer to the footnote on Figure 5 for further explanation). No information is currently available on the assets of senior citizens.

⁶It should be noted that while income decreases sharply for the total 65+ population, it does in fact increase for females. This is due to a majority of unemployed women in the 15-64 year age group and to government income subsidies for senior citizens that are equal for both sexes.

⁷Sex ratio: the number of males per 1,000 females in a population.

Another factor which will influence the types of programs and facilities needed by the elderly in the future is the family status of those 65 years of age and over. The proportion of the elderly population within the categories of single, widowed, divorced, and/or living alone is an important indicator of need as these persons are less likely to have someone to rely on for support in everyday living. If they become acutely or chronically ill, they are more likely to require assistance from outside the home. Table 11 shows the 1971 distribution of the elderly by marital status. While 51.5 per cent of women 65 years of age or older were widowed, only 15.3 per cent of the men were widowers (reflecting the greater life expectancy of females). As a remnant of the "frontier era", 12.6 per cent of men were single compared to only 4.7 per cent of women. This contrasts with the total Canadian elderly population which has equal proportions of single elderly males and females.

Table 12 shows that:

- (1) 66 per cent of elderly males were heads of families (i.e., living with a spouse and/or unmarried child) and six per cent of elderly females were heads of families
- (2) 34 per cent of males and 57 per cent of females were not living with either a spouse and/or unmarried child
 - 16 per cent of males (9,415) and 28 per cent of females (16,325) were living alone
 - approximately four per cent of both males and females were lodgers
 - six per cent of males and nine per cent of females were in institutions (primarily nursing homes and senior citizens' lodges)
 - approximately nine per cent of males and 22 per cent of females were living with a relative other than a spouse or unmarried child

The fact that some 25,000 senior citizens (21.4 per cent) were living alone in 1971 is of special importance in considering the development of appropriate services.

Yet another factor which may influence the planning of programs and services is the ethnic background of Alberta's elderly population. Alberta's history has involved an in-migration of different nationalities and this is reflected in the 1971 ethnic distribution of the elderly (Table 13). In comparison with the total Canadian elderly population, greater proportions of our elderly are of German, Ukrainian, Scandinavian or Polish extraction. These ethnic concentrations are also evident in Table 14, which shows the language most often spoken at home. In comparison with the total Alberta population, greater proportions of the elderly speak Ukrainian, German or Polish at home. Although it is possible that these people

are fluent in English as well as their native tongue, many may have difficulty obtaining the services they need from English-speaking agencies. The problem of a language barrier should decrease as persons 45-64 years of age and over join the present senior citizen population.

The needs of future generations of retired persons will not be the same as those of today's senior citizens. The aged of the future will be healthier and better educated. As programs and services are planned with today's older people, it is important to maintain flexibility to meet tomorrow's changing needs and requirements. Most important, though, is the need to develop programs on a sound information base so that resources are used effectively, and relevant services are developed.

PART TWO -- HEALTH AND SOCIAL SERVICE NEEDS OF OLDER PEOPLE

As the populations of industrialized countries have "aged", there has been a corresponding increase in the need and demand for services for older people, and an increase in the number of research studies on aging and the elderly. Such studies are essential because good planning requires accurate knowledge of the target group. Furthermore, research (particularly interview surveys of the elderly) can give planners not only factual information, but also insights into the ways in which the elderly perceive their needs and/or concerns, and the services available or required. Although there are many limitations to survey research, interview surveys are one method of obtaining input from elderly people into the planning processes which affect them. If the sampling is adequate, planners may be able to describe a true cross-section of the older community (including both the ill and the well; the needy and the independent), thus lessening the effects of planning based only on information about those elderly persons having known problems and utilizing services.

Such cross-sectional studies of the elderly in Western Europe and North America have shown that age generally brings with it an increase in chronic conditions and physical impairments, mainly in motor and sensory abilities. For example, the National Health Survey in the United States (1968-69) showed that 86 per cent of those 65 and over had one or more chronic conditions and a later report from the National Centre for Health Statistics found a significant increase in impairment of function as age increased. A study of a random sample of persons 65 years of age and over in a small town near Glasgow, Scotland found that morbidity increased markedly at 70 years and that common problems, which increased with age but were nearly all remediable, were cardiac

failure, anemia, coronary symptoms, deafness and failing sight (Andrews *et al*, 1971). A study (Akhtar *et al*, 1973) showed the prevalence of major disabilities -- defined as inability to maintain existence at home without help -- increased with age until by age 85 almost 80 per cent of those examined had a major disability.

Other studies have emphasized that in view of the increases in disability (often remediable disability) with age, a certain percentage of the elderly need comprehensive health and social services. Ethel Shanas, in an article published in 1969, estimated that one-seventh to one-quarter of those living in the community needed such health services.

Considerable research has been conducted in Canada, and there have been a number of special commissions and task force reports which have examined the health and social service needs of the aged. Examples of a few of these are the Senate Special Committee on Aging, 1966; the Ontario Legislative Assembly Select Committee on Aging, 1967; the Saskatchewan Senior Citizens Commission report, If you feel Change is Possible..., 1975; A Study of Community Care for Seniors, Social Planning and Review Council of British Columbia (1972); Aging in Manitoba, a survey of 5,000 elderly and all known resources in the province (1973). The recommendations are much the same from all these reports -- the need for a broad range of comprehensive services, the need for making knowledge about services available to the public and in particular to older persons. The Saskatchewan study indicated the lack of knowledge on the part of older people about services. The British Columbia study suggested that approximately 15 per cent of the elderly living in the community need supportive services either intermittently or on a long term basis. The Manitoba survey found that services were either unknown to the elderly, or psychologically or physically inaccessible.

Services, it was determined, should be decentralized and delivered into the homes of the elderly, and there should be greater communication with the elderly about the services. The study also showed a need for help with independent housing, and highlighted the social isolation of the elderly with the resulting need for community services, home care services, preventive health services, and easier access to medical and rehabilitation services.

Papers from the Long Range Health Planning Branch, Department of National Health and Welfare, have related the available demographic information and present utilization of health services by the elderly to future needs and possible utilization.¹ Both have strongly suggested the importance of

¹J. A. Clark and N. E. Collishaw, "Canada's Older Population", Mary K. Rombout, "Health Care Institutions and Canada's Elderly, 1971-2031"

examining alternative and more appropriate forms of health care, in view of the growing numbers of old and in particular the very old. Rombout suggests that if we continue our present policy we should consider that we may have to provide for nearly 53 million patient days in 2031 in acute care facilities just for the aged portion of our population. In view of the fact that this is a very expensive form of health care, this should be incentive enough, she suggests, for us to test out and plan alternatives such as home care and day care; in addition, a more important concern is "the happiness and well-being of our older citizens".

Alberta has also produced studies and writings on its elderly population. A summary of many of the briefs and writings can be found in the Continuum of Care for Senior Adults in Alberta. There have been seven studies since 1971 which involved actual interviews with older people.² While the questions asked did vary, and therefore the information obtained is not always comparable, these studies do help us to obtain, along with the demographic information some basic knowledge about our senior citizens. Detailed information from these studies can be obtained from the Senior Citizens Division, Alberta Social Services and Community Health.

Most of the elderly interviewed in these seven studies from both urban and rural parts of Alberta described themselves as being in generally good health, although somewhat over 50 per cent had at least one chronic condition (cardiovascular, circulatory, and muscular/skeletal problems were most common). Vision and hearing problems were the major sensory defects reported. The health study in Edmonton showed that those who were older, and living alone, had the lowest levels of physical health and morale, and the least knowledge of community resources. Both this study and Operation New Roof indicated

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1. Lacombe Council on Aging Survey, 1970 (total elderly)
 2. Operation New Roof, 1973 (random sample)
 3. The Medical Services Research Project: Health Care and the Non-Institutionalized Senior Citizen in Alberta, 1972-73 (random sample)
 4. Survey of the Characteristics and Lifestyle of Persons 65 Years and Over, in Calgary, July - August, 1971 (random sample)
 5. The Continuum of Care for Senior Adults in Alberta, 1973-74 (random sample)
 6. Senior Citizens Survey: Smoky River Municipal District No. 30, June 1974 (total elderly)
 7. Senior Needs Survey Report: Provost and District Preventive Social Services (total elderly)

A study in the Wainwright area is not summarized because, while it did include interviews of the elderly, it was a survey of the general population.

that morale and life satisfaction were definitely related to the status of an older person's health. The majority of the elderly were living in the community and more than 50 per cent were in their own homes (the rural studies showed more elderly in lodges or nursing homes). About 20 to 35 per cent of the older people surveyed were living alone. Loneliness, finances and health frequently emerged as major areas of concern as well as transportation (the latter particularly in rural areas).

Those four studies that made recommendations suggested the need for co-ordinating mechanisms, more home support services, programming that more adequately reflects chronic health care needs and of the "outreach home-centered" variety, increased information services, and increased pensions.

There are still many questions concerning the health and social service needs of the elderly in Alberta. Only one study has looked at the needs and life satisfaction of older people in lodges and nursing homes. No study has examined waiting lists for lodges and nursing homes, nor looked in depth at the reasons older people enter this kind of care and whether or not such placement is really appropriate. Little work has been done on the extent and quality of family support. An examination of some of these areas would be helpful if we wish to formulate relevant social policy. Information available from studies elsewhere could be used more effectively and we could examine more carefully that available from our present services described in Part Three. Such data, if well collected, could increase our understanding of both the situation of the elderly in Alberta and effective intervention.

PART THREE -- UTILIZATION OF SERVICES BY THE ELDERLY

The studies reviewed in Part Two indicate that the elderly (particularly those over 75 years of age) suffer from a higher prevalence of chronic disease and disability, and often have more adverse reactions to acute illness. One would, therefore, expect that the elderly would utilize a relatively higher amount of health care than younger age groups. Despite evidence of higher utilization of health services, one is still left with the question of whether the care received is adequate in volume and appropriate in type, relative to the needs of the elderly.

Although persons 65 years of age and over constituted only 7.5 per cent of the Alberta population, in 1973/74 they utilized 14.3 per cent of all physician services (see Table 15). On the average, elderly

males used 12.8 physician services during the year, and elderly females, 13.7 physician services. In comparison with the total population, the elderly utilized almost all types of services more frequently (except obstetrical and minor surgery), particularly house and hospital visits (see Table 16). An elderly person's relative utilization of general hospitals in Alberta in 1972 averaged almost eight days per year, in comparison with one to three days per year for the other age groups (see Table 17). The difference is due to both a higher admission rate for the elderly, and a longer average length of stay once they have been hospitalized (16 days as compared to from 7 to 11 days). Part of the high volume of hospitalization for the elderly is explained by the absence of alternative, more appropriate types of health care in an area. Excluding active treatment hospitals and senior citizens' lodges, 7.5 per cent of Alberta's elderly were in long-term institutional care in 1974¹⁰ (see Table 18). Adding the lodges raises this figure to 10.9 per cent. Compared to the average of five per cent institutionalization for other industrialized countries such as the United States, Britain and Denmark (Shanas, 1961), Table 18 reflects Alberta's institutional perspective on care for the elderly in the past and present.

As of August 1975, Alberta had a total auxiliary hospital capacity of 2,706 beds (excluding the Henwood Rehabilitation Center) and a nursing home capacity of 6,869 beds, with an additional 255 beds under construction. Persons 65 years of age or older account for 62 per cent of auxiliary hospital patients and 91 per cent of nursing home patients¹¹ (see Table 19). A further age breakdown of nursing home patients shows over 40 per cent are 85 years of age or over. If these figures can be applied to all nursing home patients in Alberta, a total of 24.4 per cent of the Alberta population 85 years of age and over are resident in nursing homes.

The annual patient census by the Alberta Hospital Association on October 16, 1974, determined the distribution of nursing home patients by the type of care required, ranging from Type 1 (ambulant person primarily requiring supervision

¹⁰Includes auxiliary hospitals, nursing homes, psychiatric hospitals and homes for special care.

¹¹An auxiliary hospital in Alberta is defined as a facility which provides skilled nursing care and medical monitoring for terminally ill, permanently disabled, short-stay convalescent, and long-term rehabilitation patients. A nursing home in Alberta is defined as a facility which provides personal care with nursing supervision.

and/or assistance with activities of daily living) to Type 5 (acute care normally provided in an active treatment hospital).¹² Approximately 30 per cent of nursing home patients required only Type 1 care, and another 50 per cent only Type 2 care. Only about three per cent required Types 4 or 5 care. As shown in Table 20, however, there was considerable regional variation in this pattern. The mix of patients by type of care required is a result of several factors, including the relative availability of other institutional beds and/or community-based services in the area, the assessment criteria employed, and the amount and type of discharge planning.

It is difficult to obtain an accurate provincial estimate of persons waiting to be admitted to auxiliary hospitals or nursing homes, as many individuals may have their names on two or more waiting lists. The following list provides some examples of the variation in size of waiting lists (as of August 1975).

Number of Persons on Waiting List for:

<u>District</u>	<u>Auxiliary Hospital(s)</u>	<u>Nursing Home(s)</u>
Barrhead	*	14
Calgary	84	33
Cardston	-	3
Drumheller	23	25
Edmonton	234	227
Grande Prairie	7	10
High Prairie	*	-
Lamont	8	30
Medicine Hat	30	60
Provost	*	13
Red Deer	-	100

*No auxiliary hospital in district.

The difference in size of the Calgary and Edmonton waiting lists appears to be due to three factors: (a) a relatively greater supply of beds in Calgary (including general hospital beds); (b) Edmonton serves a larger "catchment area", as Medicine Hat and Lethbridge drain off some of the bed demand that would otherwise go to Calgary hospitals; and (c) possible differences in methods of managing the waiting lists in the two cities (e.g., assessment procedures).

¹²The data provided by this patient census should be viewed as only an estimation of the nursing home population for two reasons: (a) assessment of patients by type of care required remains a fairly subjective procedure; and (b) only 62 of Alberta's 75 nursing homes responded to the A.H.A. survey questionnaire. Please refer to Table 20 for the full definition of the five types of care employed in this patient census.

Institutional care involves costs both to the government and to the individual. The following shows the approximate total per diem costs of operating an institutional bed, and the cost incurred by the patient¹³:

Institution Type	Approximate per diem operational cost	Cost incurred by patient
Active Treatment Hospital	Ranges \$67 - \$131	- \$5 admission charge (covered by Extended Health Care for persons 65 years and over). - no additional charge for standard ward accommodation. - semi-private and private ward accommodation are charged to the patient, unless he is covered by Alberta Blue Cross or some other Insurance Plan.
Psychiatric Hospital	\$44	- \$3 per day after the first 120 days.
Auxiliary Hospital	\$35	- \$4 per day after the first 120 days for standard or semi-private accommodation, and \$3.50 for private accommodation.
Nursing Home	\$18	- \$4 per day for standard ward accommodation. - \$6 per day for semi-private accommodation - \$9 per day for private accommodation

SOURCE: Alberta Hospital Services Commission, and Mental Health Services, Jan.1, 1976

¹³ Costs incurred by patients for (1) active treatment and auxiliary hospitals when they are insured under the Alberta Health Care Insurance Plan which includes registration under the Alberta Hospitalization Benefits Plan, and (2) nursing homes when they are insured under the Alberta Nursing Home Plan which has an Alberta residency requirement.

In addition to people in nursing homes and auxiliary hospitals, the Homes and Institutions Branch of Alberta Social Services and Community Health operates three institutions (Homes for Special Care) with close to 600 elderly patients. The cost of care in these institutions is \$3.00 per day paid by the resident, and \$21.69 - \$23.64 per day per patient paid by the department. There are another thirteen privately operated homes for special care which provide room and board, and varying degrees of care, for about 900 elderly residents. The residents pay for their own room and board; any operating deficit is covered by the voluntary association operating the home.

Alberta has 83 senior citizens' lodges with 4,125 residents. The lodges provide room and board, but few special services as the residents are expected to be in good health. There are at least another 20 lodges in planning or construction stages. Information about the age of lodge residents, or the total number of persons on waiting lists, is not as yet available. Residents pay up to \$130 per month for a single room, \$115 each for a double room. The municipalities are responsible for financing the operating deficits of these lodges; the estimated average annual deficit per lodge was \$28,000 in 1974/75.

The Division of Mental Health Services provides in-patient services. The Division maintains a geriatric bed capacity of 414 between the two Alberta hospitals, at Edmonton (Oliver) and Ponoka. The approximate per diem operational cost of one of these beds was \$44 in 1974/75. Over the past several years the Division has been shifting its focus from in-patient care to out-patient, community based services.

In many areas of the province, the only way an elderly person can obtain help is to be admitted to a lodge or a nursing home. An added incentive to seek institutionalization is that both lodges and nursing homes are subsidized (the former by municipalities and the latter by the Alberta Hospital Services Commission) so that it is less costly for an older person - or for his family - to enter sheltered care than to live independently. While it is recognized that sheltered care is necessary and appropriate for some older people, the authors feel that admission to both lodges and nursing homes should be on the basis of a careful assessment of total need - physical health, functioning level, social and emotional health, and family support.

In community care there are three geriatric day hospital programs, serving a total of up to 75 persons a day. These pilot programs, financed by the Alberta Hospital Services Commission, are now being evaluated. They are intended to help people achieve and maintain independence, and to prevent or delay admission to nursing homes or auxiliary hospitals by providing day care and therapy to those living in the community.

Another important component of the community care system is home care, or home-delivered health and social services. Alberta is only now beginning to become more involved with this type of health care, in contrast to the well-established home care programs in Europe, and the programs operating in other Canadian provinces (e.g., Ontario, British Columbia and Manitoba). It is estimated that 26 per cent of the elderly in Sweden receive some form of in-home assistance, with comparable figures of 11 and 15 per cent respectively for Norway and Denmark (Aging, April 1975). In Alberta, home care programs presently are operating in nine communities: Banff, Calgary, Didsbury, Edmonton, Leduc, Manning, Olds, Red Deer, and Wetaskiwin-Ponoka. These programs are offering home nursing services along with meals-on-wheels, and in some areas, home help. Taber-Coaldale provides a home help service only. Because most of the programs are relatively new there are no reliable provincial utilization data available for this article (Table 21 provides some information of the Calgary and Edmonton home care programs for the fiscal year 1974/75). As of November 1975, there were 765 people receiving home care in the province, 75 per cent of whom were over 60 years of age. There is considerable variation among the caseloads of these home care programs. Through the new senior citizens community service program of Preventive Social Services, five new home help/repair services have been started for elderly people (Edmonton, Calgary, Coaldale-Taber, Lacombe, Lethbridge). Over half the provincial senior citizens community service fund is used for non-medical home delivered services (e.g. meals-on-wheels programs, non-medical aspects of Edmonton's home care program and homemaker projects). It is suggested that such programs should not replace family help, rather it should encourage and enable family help.

The public health units of Alberta Social Services and Community Health are involved in, or operating, many of the home care programs previously mentioned. In addition to this perspective of maintaining patients who require nursing care in their own homes, health units are now involved in health counseling and surveillance programs for the elderly. This year

additional provincial funds have been allocated to ten health units to enable each of them to increase their community nursing staff by one nurse.¹⁴ This will decrease the individual caseloads and enable them to spend more time in providing preventive service for the elderly. Both the home care and health surveillance programs reflect the increasing emphasis of public health units on provision of care to the elderly.

Like the public health units, mental health out-patient clinics have had a primary focus on children's services, and are only more recently adding resources to enable the provision of services to the elderly. One area of particular need has been requests from nursing homes to provide first-contact mental health consultation to some of their patients.

In general, Tables 15 through 21 have shown high health care service utilization by the elderly, with a historical focus on institutional as opposed to community-based care. Aside from medical doctors, relatively few of the health services are serving the community elderly. There are no Alberta doctors with special training in the field of geriatrics at this time, and there are no special community or hospital-based assessment clinics for the elderly.¹⁵

The physical health and functioning of an elderly person is closely related to his social and emotional environment and to other factors such as housing and income. The provision of adequate social support services, housing, income supplementation and the financing of health care, are most important in maintaining "health", in the sense of maintaining "well-being" in the older person. Any serious effort to develop community care programs for the elderly must involve the development of a range of programs that are not "health" programs in the traditional sense. It is these programs and services that are often most important in helping the older person maintain an active role in society.

¹⁴Funding for local health services is provided by the provincial government. These ten health units have a total number of 34,697 persons 65 years and over - Mount View, Wetoka, Lethbridge, Medicine Hat, Barons-Eureka, Alberta East Central, Vegreville, Red Deer, Foothills, and Sturgeon.

¹⁵The Senior Citizens Central Council of Calgary now has a health screening and counselling clinic for older people located at the Kerby Center - a multipurpose senior centre in Calgary. The clinic is under the direction of the Professor of Family Practice, Faculty of Medicine, University of Calgary, and is staffed by residents in Family Practice and a social worker. Retired doctors and other professionals volunteer their services. This project is being supported through a grant from the Special Projects Fund of the Senior Citizens Division of Alberta Social Services and Community Health.

Because of the economic dependency of senior citizens, there are a variety of government income security programs designed to assist senior citizens. As shown in Table 22, the Old Age Security program (O.A.S.) provides a flat rate payment to persons over 65 of \$132.90 (January 1976 rates). In addition, there is an income supplement of up to \$93.22 per month for single pensioners with no or low income from the Government of Canada, and up to \$45.01 per month from the Government of Alberta. Hence, senior citizens over the age of 65 are guaranteed \$271.13 per month in Alberta, and couples, \$525.76 (January 1976 rates). There is a high percentage of pensioners with no outside income other than government payments. Of the 130,868 persons receiving Old Age Security in Alberta in August 1975, 57.2 per cent received the Guaranteed Income Supplement (G.I.S.) with 22.8 per cent receiving the full supplement, and 34.4 per cent a partial supplement. In total, 74,864 pensioners in Alberta (57.2 per cent of total) were eligible for the Alberta Assured Income Plan (A.A.I.P.) in August 1975. The above information means that 57.2 per cent of Alberta's pensioners had a monthly income of \$331.00 or less (as of January 1976); 22.8 per cent of all pensioners are living on only the guaranteed minimum monthly income of \$271.13 (a little less if married) per month.

Both the federal and provincial levels of government have allocated a portion of their budget toward expenditures for the aged. In the 1973/74 fiscal year, the federal government spent \$2.3 billion on O.A.S. (\$154 million in Alberta), \$760 million on G.I.S. (\$54.8 million in Alberta), and \$37 million is budgeted for the A.A.I.P. program by the Alberta government for the fiscal year 1975/76. Thus, substantial progress has been made in income security areas towards the economic protection of the aged by both levels of government.

All 128,000 senior citizens and their dependents are covered (with no premium charge) by the Alberta Health Care Insurance Plan, the Alberta Blue Cross Plan, the Hospital Benefits Plan, and the Extended Health Benefits Plan. The Blue Cross Plan pays all but 20 per cent of the cost of prescription drugs. The Extended Health Benefits Program provides financial assistance for hearing aids, dental care including dentures, eye glasses, and a broad range of medical and surgical appliances, equipment and supplies. In 1974, the Program provided 6,552 hearing aids, 33,189 new eye glass lenses, and 730 replacements of eye glasses.

There are now 33 senior citizen housing projects in operation, with about 2,347 self-contained units and 555 cottages attached to lodges.¹⁶ These

¹⁶Some of these cottages are double units for couples, so the actual number of people accommodated is greater than the number of units.

apartments and cottages rent at a subsidized rate; however, few, if any, services are provided within these housing projects,¹⁷ even though we are becoming increasingly aware of the importance of such services in maintaining older people at a good level of functioning.

The Alberta Department of Housing and Public Works, through its new Senior Citizens Home Improvement Program, is providing grants of \$1,000 to needy senior citizen resident home owners for home repair. Many of the studies of needs of the elderly reviewed in Part Two of this article have pointed out the necessity for this type of assistance to older persons (particularly females) in their own homes.

In the area of social recreational programs for the elderly, the Federal New Horizons program had funded a total of 247 projects in Alberta as of June 1975. Through these projects, the federal program has provided support for self-help endeavors to keep senior citizens active and involved. The projects have included such things as furnishing/renovating club rooms; assisting in the areas of arts and crafts, writing, and historical projects; and supporting volunteer service projects. In addition to providing added support to already organized senior citizen groups, New Horizons in Alberta has encouraged the development of new senior citizen organizations.

In 1975-76 the provincial government allocated special funds to Preventive Social Services (P.S.S.) for the development of senior citizens community projects. While some programs had already started in previous years, the Senior Citizens Community Service Program of P.S.S. made increased provincial funds available to local P.S.S. Boards for programs for older people - home support programs such as home help, repair help, chore help, and meals-on-wheels, as well as drop-in centres, out-reach programs and information services. There are now three information and referral services (one receiving partial funding), four out-reach neighbourhood services, and thirty-one drop-in centres receiving some funding for operational expenses. Some senior centre programs provide services as well as social-recreational opportunities. These services include the information/counselling services previously mentioned, food services, health counselling, out-reach services, visiting and telephone services. The information/counselling/referral service in Edmonton handled approximately 1,200 requests in October 1975. As yet, no data on these various community-based

¹⁷ An exception to this situation is the location of a senior citizens social/recreation centre, operated by a voluntary board, in the new Confederation Park Lodge in Calgary. The centre is open to both the elderly in the community and lodge residents. The centre's operating budget is provided by Preventive Social Services of the City of Calgary and Alberta Social Services and Community Health; the accomodation by Alberta Housing and Public Works.

non-medical programs have been collected so the total extent of utilization by Alberta elderly of such programs is not known, nor the characteristics and needs of the users. Table 23 lists the senior citizens' projects funded through this allocation as of October 1975.

The development of community based social support programs for senior citizens in Alberta is dependent on municipalities entering the Preventive Social Services program and on the priority-setting of each municipality - its assessment of the needs of the elderly, its willingness to financially support (20 per cent of the funding for a grant) such social support programs for older people, and the approval of the provincial Preventive Social Services Branch (80 per cent of the grant for a project is provincial funding). As of August 1975, approximately 26 per cent of the elderly in Alberta were living in areas not covered by Preventive Social Services, so provincial funding for community-based programs is unavailable to them. We need to find ways to give them these opportunities.

In 1975/76 the total provincial Preventive Social Service budget was \$8.9 million. The amount allocated to the Senior Citizens Community Service program was \$1.2 million (13 per cent).¹⁸ Figure 8 shows the distribution of all preventive funds. More than half of the senior citizens' allocation (\$700,000) is financing home support services in operation or just beginning.

The new Senior Citizens Division in Alberta Social Services and Community Health will provide a focal point for information about programs and services for senior citizens, and for the collection of information and data about the elderly.¹⁹ It will be a resource for both individuals and for agencies and organizations, public and private, working with older people. It will work with other branches and departments of government, particularly Preventive Social Services and Local Health Services, to encourage cooperation and development of a continuum of coordinated programs for senior citizens. The Division itself will provide no direct programs. It will administer two modest funds: (1) grants for education in gerontology and geriatrics, and (2) grants for special projects; and the grant to the Alberta Council on Aging, a voluntary

¹⁸This represented a large increase over the 1974/75 budget and was due to the special allocation of provincial funds in 1975/76 to the Senior Citizens Community Service Program. Included in the \$1.2 million are varying proportions of the budgets for services utilized by people of all ages (refer to Figure 8), as well as the budgets of those programs geared especially for older people.

¹⁹A recent publication that is available on request to the Senior Citizens Division is Programs and Services for Senior Citizens in Alberta (September 1975), which describes all of the existing programs and services available to Albertans 65 years and older.

province-wide organization. The Division will work with the Provincial Senior Citizens Advisory Council to be appointed by the Minister of Social Services and Community Health. The Council will provide advice to the government on services for older people.

As one can see from the foregoing, several government departments are involved in services for older people. It is hoped that the future will bring more co-ordination in both the planning and development of such programs.

SUMMARY

The population of Alberta has "aged" dramatically over the last 75 years, and this trend is projected to continue into the future. By the year 2001, over 10 per cent of the population will be over 65 years of age.

This shift in the age composition of the Alberta population will be reflected in modifications to existing government programs and the development of new programs. In the past, Alberta has had an institutional perspective on health care for the elderly and has largely neglected the area of social service programming (other than income security) for this age group. For economic and philosophical reasons, the province is now moving towards community-based health services for the entire population, including the elderly, complemented by an increasing range of social service programs. Initial assessment and periodic reassessment of the needs of senior citizens, both at the local and provincial levels, will aid in modifying both health and social service programs to meet the needs of the elderly, and enhance their physical, social and emotional well-being.

In looking at our social policy for the elderly in our province, we could well ask ourselves the following: Do our present programs and services encourage independence in the older person or do they encourage helplessness and dependence? Are these the programs and services that will be satisfactory for the coming generations of older people?

Perhaps the most important resource available towards the development and improvement of programs for the elderly is the capacity of this increasingly informed and interested group to set their own directions and provide guidance to government and private agencies. The majority of the elderly are healthy, active and vital individuals who can become constructively involved in the planning process.

TABLE 1 PERCENTAGE OF POPULATION AGED 65 YEARS
AND OVER, SELECTED COUNTRIES, 1973

Country	Percentage of Population 65 Years and Over
Germany (East)	15
Austria	14
Belguim, France, Norway, Sweden, United Kingdom	13
Denmark, Germany (West), Luxembourg	12
Czechoslovakia, Hungary, Ireland, Switzerland	11
Greece, Italy, Netherlands, United States	10
Bulgaria, Iceland, Malta, Portugal, Spain	9
Australia, Canada, Finland, New Zealand, Poland, Romania, Uruguay, U.S.S.R.	8
Argentina, Barbados, Cyprus, Gabon, Guinea, Israel, Japan, Puerto Rico, Yugoslavia	7
Southern Africa, Southwest Asia, East Asia, Latin America, Caribbean	4
Northern, Eastern & Middle Africa, Middle-south Asia, Middle America, Tropical South America	3
Western Africa	2
WORLD AVERAGE	5

Source: Population Reference Bureau, 1973 World Population Data Sheet.

TABLE 2 PERCENTAGE OF POPULATION AGED 65 YEARS AND
OVER, CANADA AND THE PROVINCES, 1971

Province	Percentage of Population 65 Years and Over	Rank
Newfoundland	6.14	10
Prince Edward Island	11.06	1
New Brunswick	9.19	5
Nova Scotia	8.62	6
Quebec	6.85	9
Ontario	8.37	7
Manitoba	9.67	3
Saskatchewan	10.24	2
Alberta	7.29	8
British Columbia	9.38	4
Yukon	2.83	11
Northwest Territories	2.17	12
CANADA	8.09	--

Source: Census of Canada 1971.

TABLE 3 PERCENTAGE OF POPULATION 65+ and 85+ YEARS,
ACTUAL AND PROJECTED, ALBERTA, 1901-2001

Year	Total Population	Population 65 Years and Over		Population 85 Years and Over	
		Number	As % of Total Population	Number	As % of Total Population
Actual:					
1901	73,022	1,413	1.94	66	0.09
1911	374,295	6,222	1.66	185	0.05
1921	588,454	13,957	2.37	378	0.06
1931	731,605	25,963	3.55	701	0.10
1941	796,169	41,606	5.23	1,464	0.18
1951	939,501	67,283	7.16	2,421	0.26
1956	1,123,116	81,387	7.25	3,330	0.30
1961	1,331,944	93,000	6.98	4,811	0.36
1966	1,463,203	104,010	7.11	6,927	0.47
1971	1,627,875	118,750	7.29	10,270	0.63
Projected:					
1976	1,768,600	136,000	7.69	11,900	0.67
1981	1,941,200	159,600	8.22	13,300	0.69
1986	2,130,500	185,400	8.70	16,000	0.75
1991	2,311,600	215,000	9.30	19,500	0.84
1996	2,477,500	242,700	9.80	23,200	0.94
2001	2,640,400	266,100	10.08	27,900	1.06

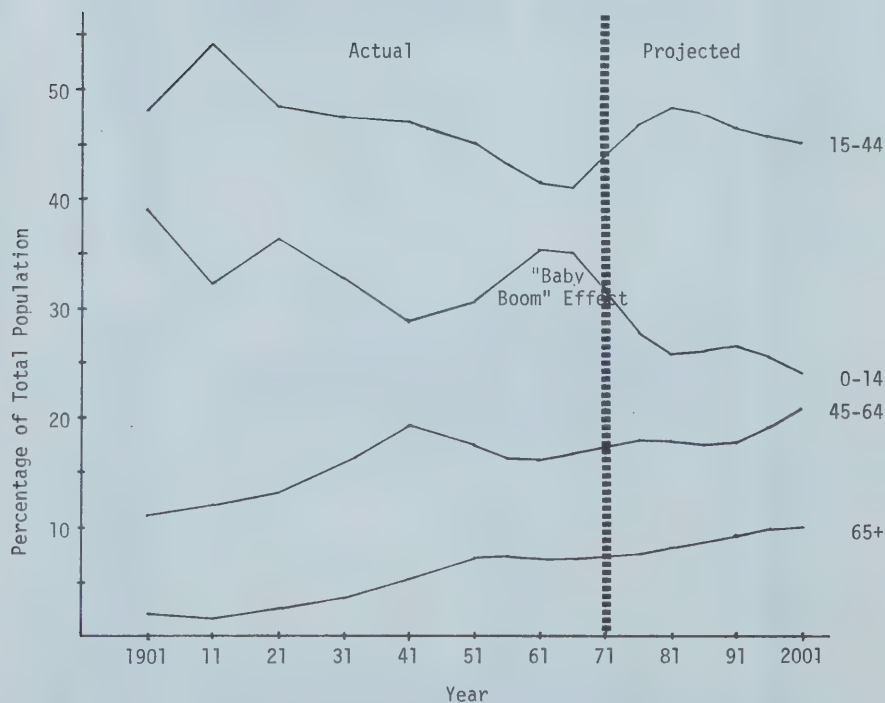
Sources: Censuses of Canada 1901 - 1971; and Population Projections for Canada and the Provinces, 1972 - 2001, Statistics Canada, Cat. no. 91-514 Occasional (projection B).

TABLE 4 ACTUAL AND PROJECTED INCREASE IN POPULATION
WITHIN AGE GROUPS, ALBERTA, 1951 - 2001

Age Group	Numerical Increase 1951 - 2001	Percentage Increase 1951 - 2001
0 - 14	346,594	120.8
15 - 24	270,732	181.1
25 - 34	208,834	140.5
35 - 44	290,320	235.1
45 - 54	242,220	261.9
55 - 64	143,042	199.6
65 - 74	103,008)	210.3)
75 - 84	70,670) 198,817	455.1) 295.5
85 +	25,479)	1052.4)
All Ages	1,700,899	181.0

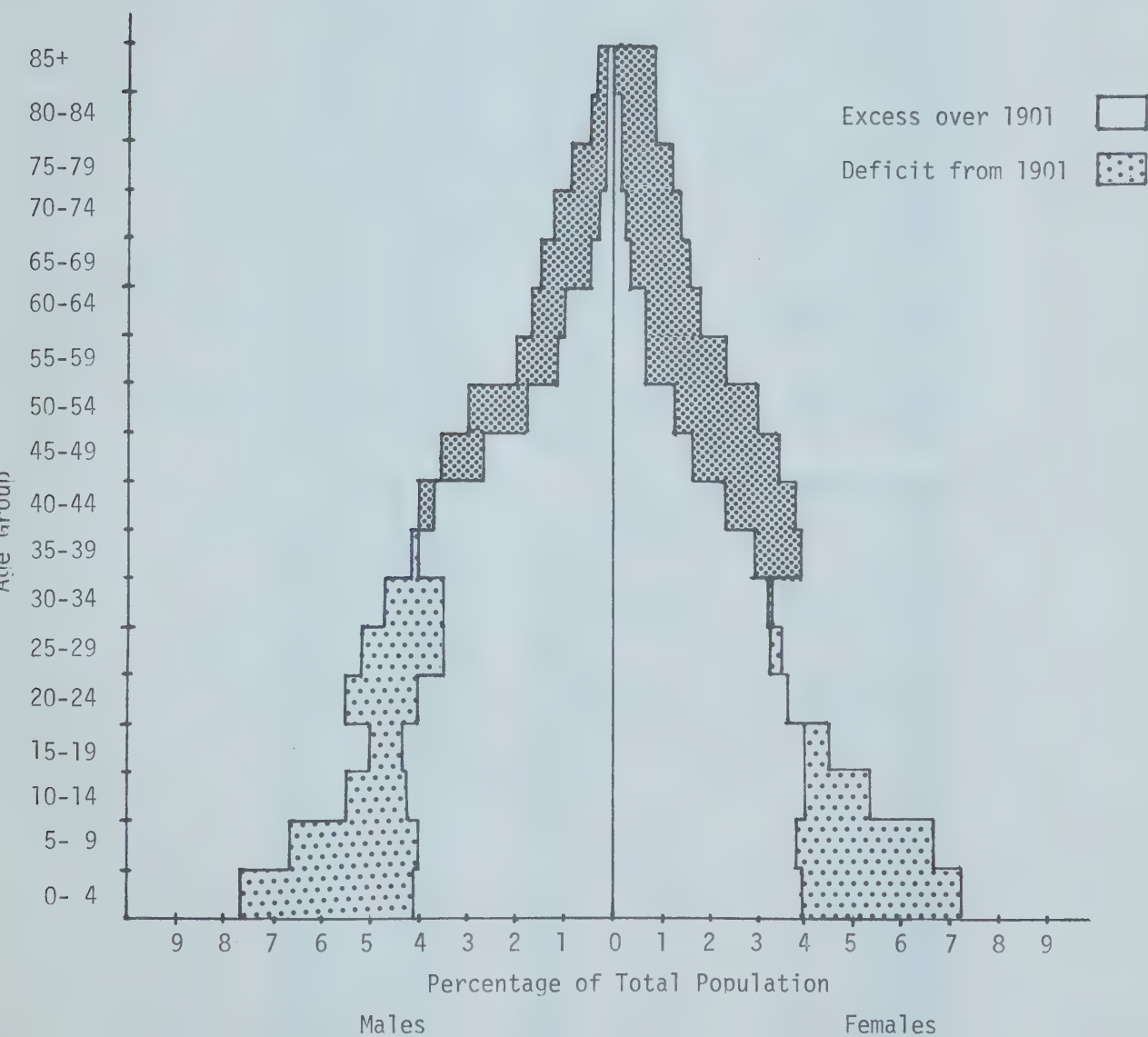
Source: Census of Canada 1951 and Population Projections for Canada and the Provinces, 1972-2001, Statistics Canada, Cat. No. 91-514 Occasional (Projection B)

FIGURE 1 AGE COMPOSITION OF THE ALBERTA POPULATION, 1901 - 2001



Source: Censuses of Canada 1901 - 1971, and Population Projections for Canada and the Provinces, 1972 - 2001, Statistics Canada, Catalogue No. 91-514 Occasional (Projection B).

FIGURE 2 AGE - SEX PYRAMIDS OF THE ALBERTA POPULATION, 1901 AND 2001



Source: Census of Canada 1901, and Population Projections for Canada and the Provinces, 1972-2001, Statistics Canada, Catalogue No. 91-514 Occasional (Projection B).

TABLE 5 DISTRIBUTION OF POPULATION 65 YEARS AND OVER BY HEALTH UNITS, SOCIAL DEVELOPMENT SERVICES REGIONS, MENTAL HEALTH REGIONS, AND POPULATION CENTERS OF 1,000 PERSONS OR MORE, ALBERTA, 1971

Geographic Area	Total Population	Population 65+ Years	
		#	As % of Total Pop.
<u>Health Units:</u>			
Alberta East Central	47,761	4,819	10.09
Athabasca	17,140	1,347	7.86
Banff	3,532	320	9.07
Barons-Eureka	26,261	2,358	8.98
Big Country	12,991	1,146	8.82
Chief Mountain	8,072	924	11.45
Chinook	23,595	2,511	10.64
County of Warner	7,977	758	9.50
Drumheller	26,401	2,513	9.52
Edson	25,879	1,286	4.97
Foothills	20,474	2,031	9.92
Grande Prairie	39,532	2,791	7.06
High Level-Fort Vermilion	6,157	357	5.80
Jasper	3,064	155	5.06
Leduc-Strathcona	48,410	3,582	7.40
Lethbridge	41,217	4,431	10.75
McMurray	15,663	753	4.81
Medicine Hat	49,834	5,203	10.44
Minburn-Vermilion	25,776	2,567	9.96
Mount View	33,326	2,699	8.10
Northeastern Alberta	32,974	2,773	8.41
Peace River	35,411	2,716	7.67
Red Deer	71,581	6,056	8.46
Stony Plain-Lac Ste. Anne	23,397	1,769	7.56
Sturgeon	51,870	3,812	7.35
Vegreville	25,525	2,473	9.69
Wetoka	27,960	2,846	10.18
<u>Social Development Services Regions:</u>			
Athabasca	9,615	1,010	10.50
Barrhead	27,095	2,580	9.52
Bonnyville	20,030	1,070	5.34
Brooks	11,170	850	7.61
Calgary North	214,450	14,385	6.71
Calgary South	235,685	14,625	6.20
Camrose	20,995	2,560	12.19
Drumheller	23,910	2,450	12.25
Edmonton North	125,010	9,830	7.86
Edmonton South	169,710	9,535	5.62
Edmonton West	225,435	11,520	5.11
Edson	20,500	1,380	6.73
Grande Prairie	38,720	2,790	7.20
Hanna	12,685	1,145	9.03
High Prairie	14,195	1,000	7.04
Lac La Biche	6,975	475	8.81
Lethbridge	99,215	9,795	9.87
Medicine Hat	39,455	3,955	10.02
Olds	16,180	1,485	9.18
Peace River	22,890	1,735	7.58
Blairmore	14,310	1,255	8.77
Red Deer	61,085	5,205	8.42
Smoky Lake	11,185	1,355	12.11
Stettler	17,565	1,740	9.91
St. Paul	12,800	1,085	8.48
Vegreville	24,415	3,080	12.62
Vermilion	20,690	2,150	10.39
Wainwright	20,270	2,270	11.20
Wetaskiwin	47,850	4,550	9.51
Fort McMurray	7,980	200	2.51
Rocky Mountain House	10,715	735	6.86
Whitecourt	8,070	425	5.27
High Level	7,825	225	2.88
Slave Lake	5,720	245	4.28
Grande Cache	2,725	15	0.55

TABLE 5 (cont'd)

Geographic Area	Total Population	Population 65+ Years	
		#	As % of Total Pop.
<u>Mental Health Regions:</u>			
Calgary Region:			
Calgary Metro Area	412,125	23,079	5.60
Remainder	68,340	6,425	9.40
Total Region	480,465	29,504	6.14
Edmonton Region:			
St. Paul Sub-Region:			
St. Paul Town	4,180	475	11.36
Remainder	62,717	5,268	8.40
Total Sub-Region	66,897	5,743	8.58
McMurray Sub-Region:			
McMurray Town	6,870	65	0.95
Remainder	2,925	155	5.30
Total Sub-Region	9,795	220	2.25
Edmonton Sub-Region:			
Edmonton Metro Area	487,220	28,745	5.90
Remainder	154,689	13,613	8.80
Total Sub-Region	641,909	42,358	6.60
Total Edmonton Region	718,601	48,321	6.72
Grande Prairie Region:			
Grande Prairie City	13,125	865	6.59
Remainder	28,978	1,623	5.60
Total Region	42,103	2,488	5.91
Lethbridge Region:			
Lethbridge City	41,215	4,405	10.69
Remainder	68,680	6,165	8.98
Total Region	109,895	10,570	9.62
Medicine Hat Region:			
Medicine Hat City	28,765	3,440	11.96
Remainder	21,415	1,310	6.12
Total Region	50,180	4,750	9.47
Red Deer Region:			
Red Deer City	27,540	1,865	6.77
Remainder	138,675	13,995	10.09
Total Region	166,215	15,860	9.54
Peace River Region:			
Peace River Town	5,040	205	4.07
Remainder	40,730	3,095	7.60
Total Region	45,770	3,300	7.21
<u>Population Centres 1,000+</u>			
Airdrie	1,089	40	3.67
Athabasca	1,765	290	16.43
Banff ^a	3,532	320	9.07
Barrhead	2,803	490	17.48
Beaverlodge	1,157	115	9.94
Bellevue	1,242	165	13.29
Blairmore	2,037	245	12.03
Bonnyville	2,587	415	16.04
Bow Island	1,159	160	13.81
Brooks	3,896	405	10.16
Calgary	403,319	25,409	6.30
Camrose	8,673	1,430	16.49
Canmore	1,538	110	7.15
Cardston	2,685	465	17.32
Castor	1,166	190	16.30
Claresholm	2,935	545	18.57
Coaldale	2,798	375	13.40
Cochrane	1,046	80	7.65
Cold Lake	1,309	75	5.73
Coleman	1,534	160	10.43

^aFigures are for total national park population.

TABLE 5 (cont'd)

Geographic Area	Total Population	Population 65+ Years	
		#	As % of Total Pop.
Devon	1,468	100	6.81
Didsbury	1,821	255	14.00
Drayton Valley	3,900	65	1.67
Drumheller	5,446	770	14.14
Edmonton	438,152	27,165	6.20
Edson	3,818	335	8.77
Fairview	2,109	245	11.62
Fort McLeod	2,715	370	13.63
Fort Saskatchewan	5,726	295	5.16
Fox Creek	1,281	5	0.39
Grande Cache	2,525	15	0.59
Grand Centre	2,088	90	4.31
Grande Prairie	13,079	865	6.61
Grimshaw	1,714	110	6.42
Hanna	2,545	360	14.15
High Level	1,614	15	0.93
High Prairie	2,354	255	10.83
High River	2,676	555	20.74
Hinton	4,911	65	1.32
Innisfail	2,474	335	13.54
Jasper ^a	3,064	155	5.06
Lac La Biche	1,791	150	8.37
Lacombe	3,436	615	17.90
Leduc	4,000	390	9.75
Lethbridge	41,217	4,430	10.75
Lloydminster	4,738	505	10.66
Magrath	1,215	170	13.99
Manning	1,071	110	10.27
Mayerthorpe	1,036	200	19.31
McLennan	1,090	135	12.86
McMurray	6,847	90	1.31
Medicine Hat	26,518	3,280	12.37
Morinville	1,475	90	6.10
Okotoks	1,247	120	9.62
Olds	3,376	375	11.11
Peace River	5,039	205	4.07
Picture Butte	1,008	135	13.39
Pincher Creek	3,227	280	8.68
Ponoka	4,414	640	14.50
Provost	1,489	250	16.79
Raymond	2,156	320	14.84
Redcliff	2,255	160	7.10
Red Deer	27,674	1,870	6.76
Redwater	1,287	125	9.71
Rimbey	1,450	200	13.79
Rocky Mountain House	2,968	235	7.92
Slave Lake	2,052	40	1.95
Spirit River	1,091	160	14.67
Spruce Grove	3,029	75	2.48
St. Albert	11,800	360	3.05
St. Paul	4,161	475	11.42
Stettler	4,168	525	12.60
Stony Plain	1,770	350	19.77
Strathmore	1,148	150	13.07
Swan Hills	1,376	-	-
Sylvan Lake	1,597	260	16.28
Taber	4,765	505	10.60
Three Hills	1,354	205	15.14
Wainwright	3,872	520	13.43
Westlock	3,246	500	15.40
Wetaskiwin	6,267	815	13.00
Whitecourt	3,202	65	2.03
Valleyview	1,708	50	2.93
Vauxhall	1,016	85	8.37
Vegreville	3,691	675	18.29
Vermilion	2,915	470	16.12
Viking	1,178	245	20.80
Vulcan	1,384	215	15.53

Sources: 1971 Census of Canada published and unpublished data.

^aFigures are for total national park population.

TABLE 6 RURAL/URBAN DISTRIBUTION OF POPULATION 65+ and 85+,
ALBERTA, 1961 AND 1971

Rural/Urban Residence	Total Alberta Population	Population 65+			Population 85+		
		#	%	As % of Total Population	#	%	As % of Total Population
Urban: 100,000 - 499,999 30,000 - 99,999 ^a 10,000 - 29,999 5,000 - 9,999 2,500 - 4,999 1,000 - 2,499	605,342 35,454 44,096 23,535 62,843 71,941	38,383 3,211 3,672 2,593 5,085 6,993	41.24 3.45 3.95 2.79 5.46 7.50	6.34 9.06 8.33 11.02 8.09 9.72	2016 186 213 222 269 430	41.90 3.87 4.43 4.61 5.59 8.94	0.33 0.52 0.48 0.94 0.43 0.60
TOTAL	843,211	59,937	64.39	7.11	3336	69.34	0.40
Rural: Non-farm ^b Farm	202,910 285,823	15,862 17,279	17.05 18.56	7.82 6.05	611 864	12.70 17.96	0.30 0.30
TOTAL	488,733	33,141	35.61	6.78	1475	30.66	0.30
ALBERTA TOTAL	1,331,944	93,078	100.00	6.98	4811	100.00	0.36
1971							
Rural/Urban Residence	Total Alberta Population	Population 65+			Population 85+		
		#	%	As % of Total Population	#	%	As % of Total Population
Urban: 100,000 - 499,999 30,000 - 99,999 ^a 10,000 - 29,999 5,000 - 9,999 2,500 - 4,999 1,000 - 2,499	858,070 41,215 81,325 49,045 101,520 65,075	52,985 4,425 6,550 4,240 11,230 6,855	44.62 3.73 5.52 3.57 9.46 5.77	6.17 10.74 8.05 8.65 11.06 10.53	4790 400 770 560 1120 740	46.69 3.90 7.50 5.46 10.92 7.21	0.56 0.97 0.95 1.14 1.10 1.14
TOTAL	1,196,250	86,285	72.67	7.21	8380	81.68	0.70
Rural: Non-farm ^b Farm	195,590 236,025	20,120 12,340	16.94 10.39	10.29 5.23	1265 615	12.33 5.99	0.65 0.26
TOTAL	431,615	32,460	27.33	7.52	1880	18.32	0.44
ALBERTA TOTAL	1,627,865	118,745	100.00	7.29	10,260	100.00	0.63

^aThis urban category includes only Lethbridge.

^bPopulation centers of less than 1,000 population.

Source: Censuses of Canada 1961 and 1971.

TABLE 7 PERCENTAGE DISTRIBUTION OF POPULATION BY
MIGRATION STATUS, RURAL/URBAN RESIDENCE,
AND AGE GROUP, ALBERTA, 1966 - 1971*

Residence in 1971 and Age Group	Migration Status 1966 - 1971 ^a					Total
	Non-Movers	Movers Within Same Municipality	Migrants			
			Within Alberta	Other Provinces	Outside Canada	
Urban (1000+):						
5-14	44.0	27.5	12.8	10.3	5.0	100.0
15-44	33.0	30.6	15.8	13.8	6.8	100.0
45-64	62.0	21.8	8.4	5.6	2.2	100.0
65+	64.2	23.6	7.6	3.4	1.2	100.0
Total	43.5	27.7	13.0	10.7	5.1	100.0
Rural Non-farm (<1000):						
5-14	45.2	24.0	22.7	6.0	2.1	100.0
15-44	37.9	24.5	25.5	8.4	3.7	100.0
45-64	63.5	17.7	14.3	3.6	0.9	100.0
65+	74.4	14.7	9.3	1.2	0.4	100.0
Total	49.0	21.9	20.8	6.0	2.3	100.0
Rural Farm:						
5-14	77.5	12.8	7.5	1.7	0.5	100.0
15-44	72.1	14.5	10.1	2.2	1.1	100.0
45-64	87.9	7.1	3.9	0.8	0.3	100.0
65+	89.2	6.8	3.0	0.8	0.2	100.0
Total	78.3	11.8	7.5	1.7	0.7	100.0
TOTAL:						
5-14	50.2	24.5	13.1	8.3	3.9	100.0
15-44	38.6	27.9	16.0	11.7	5.8	100.0
45-64	66.9	18.7	8.2	4.5	1.7	100.0
65+	68.5	20.4	7.4	2.8	0.9	100.0
Total	49.3	24.7	13.1	8.8	4.1	100.0

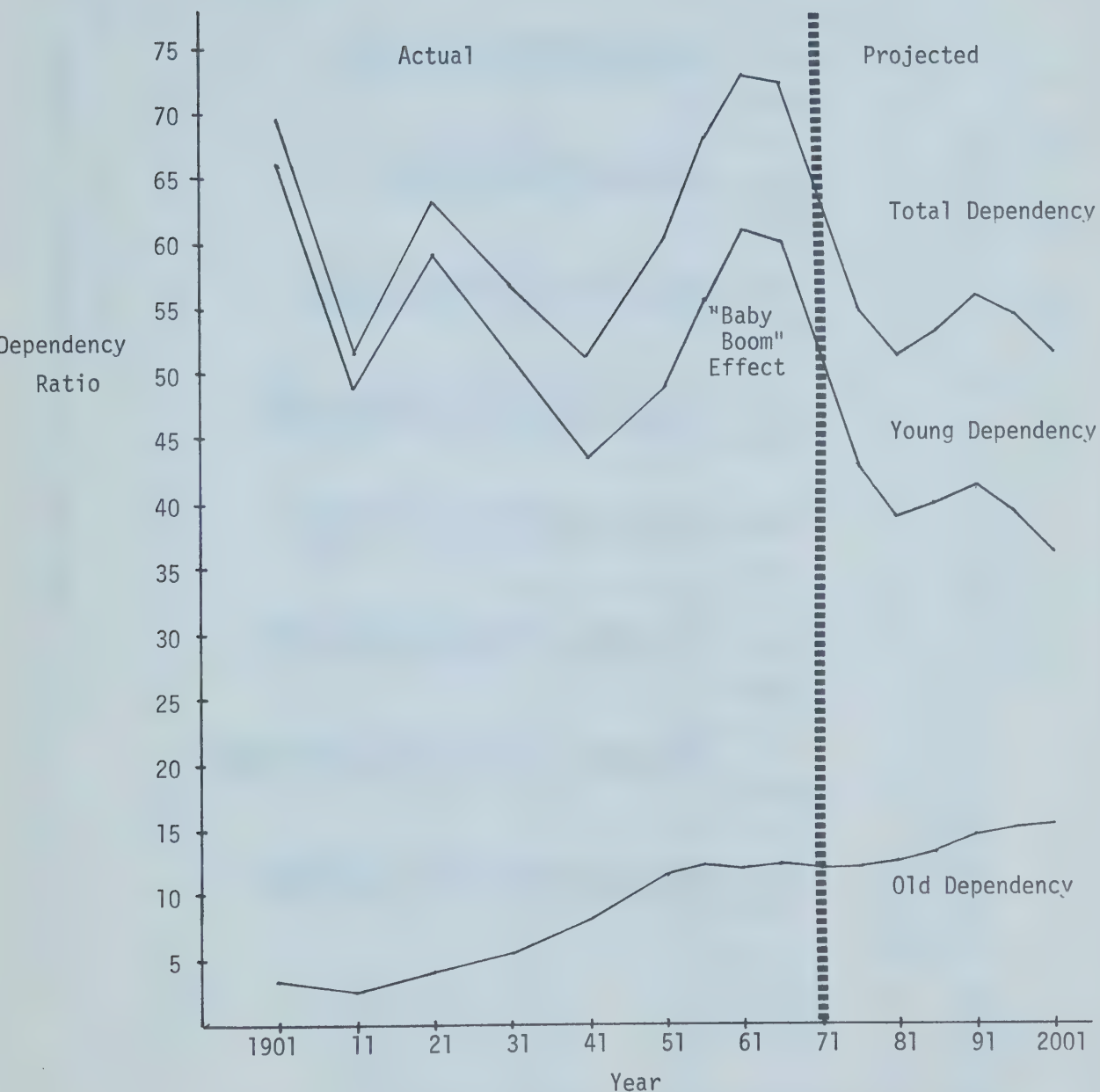
Source: Census of Canada 1971

*Excludes 22,990 persons for whom residence in 1966 was not stated.

^aNon Movers - persons reporting the same residence in both 1966 and 1971.

Movers - persons who changed their residence between 1966 and 1971, but did not cross a municipal boundary.
Migrants - persons who changed their residence between 1966 and 1971, which involved crossing at least one municipal boundary.

FIGURE 3 ACTUAL AND PROJECTED DEPENDENCY RATIOS, ALBERTA,
1901 - 2001 *



Source: Censuses of Canada 1901-71, and Population Projections for Canada and the Provinces, 1972-2001, Statistics Canada, Catalogue No. 91-514 Occasional (Projection B).

* Dependency Ratio - the number of persons 0-14 and/or 65+ years of age per 100 persons 15-64 years of age.

FIGURE 4 DEPENDENCY RATIOS BY URBAN/RURAL CATEGORIES, ALBERTA, 1971 *

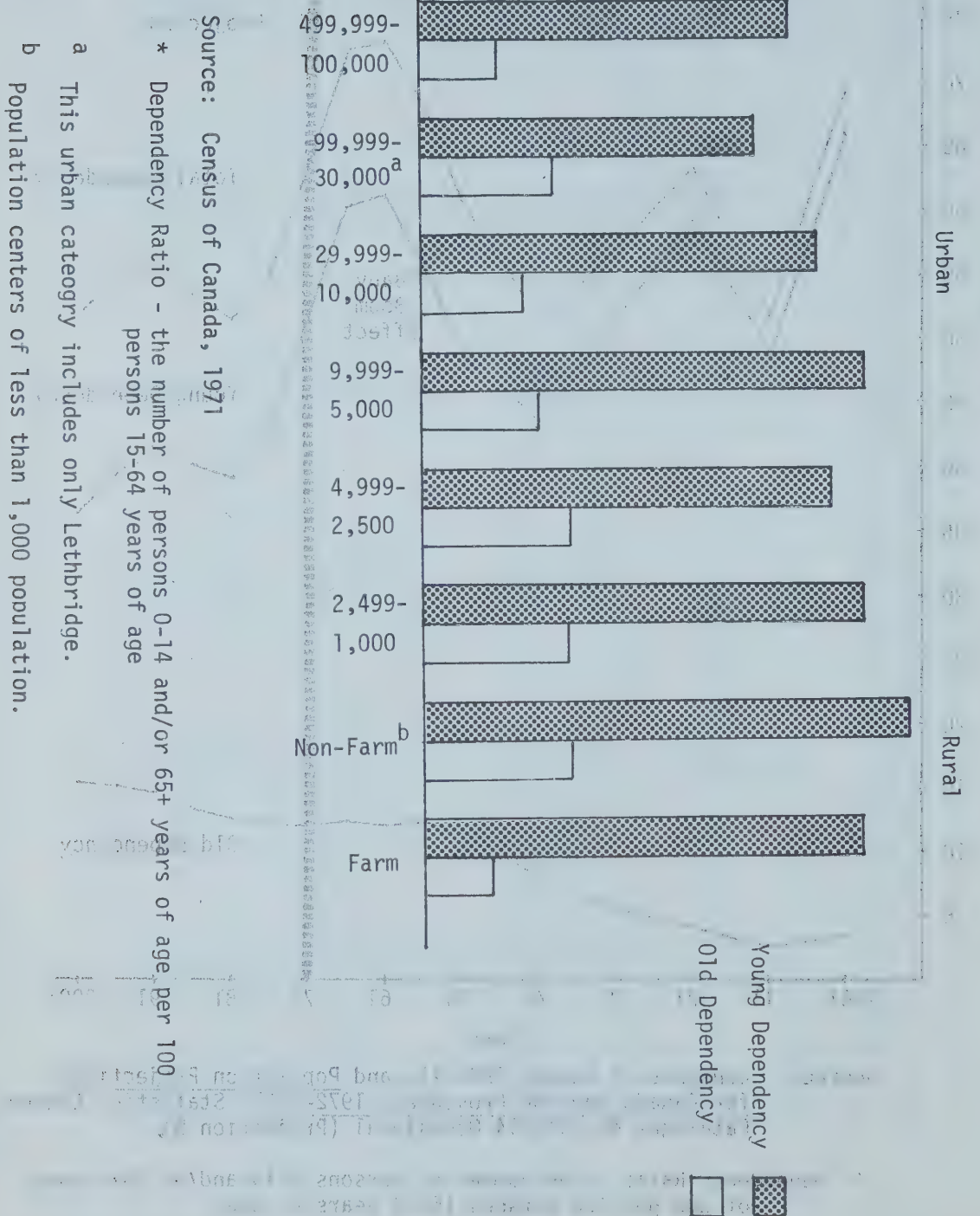


TABLE 8 LABOR FORCE PARTICIPATION RATE OF POPULATION
65 YEARS AND OVER, BY RURAL/URBAN RESIDENCE,
ALBERTA, 1971*

Rural/Urban Residence	Alberta Population 15-64 Years Participation Rate ^b			Alberta Population 65+ Years Labor Force ^a			Participation Rate ^b			Canadian Population 65+ Years Participation Rate ^b		
	M	F	BS	M	F	BS	M	F	BS	M	F	BS
Urban: 500,000+	-	-	-	-	-	-	-	-	-	24.89	8.89	15.39
100,000 - 499,999	88.15	51.75	69.87	5050	2135	7185	20.87	7.42	13.56	21.57	8.62	14.12
30,000 - 99,999 ^c	88.12	50.46	69.09	410	140	550	18.89	6.29	12.51	20.64	8.51	13.61
10,000 - 29,999	84.62	48.39	66.33	505	195	700	16.89	5.52	10.74	20.04	7.59	13.02
5,000 - 9,999	83.10	45.87	65.22	320	140	460	15.96	6.26	10.85	19.77	7.16	12.75
Under 5,000	86.65	46.53	66.42	1745	590	2335	19.09	6.36	12.68	19.92	7.01	12.93
TOTAL	87.52	50.58	68.99	8030	3200	11230	19.83	6.95	12.98	22.29	8.36	14.25
Rural: Non-farm ^d Farm TOTAL	79.54 89.58 85.41	37.47 47.46 43.07	59.53 70.58 65.86	2310 5045 7355	585 935 1520	2895 5980 8875	20.79 64.80 38.93	6.69 21.27 11.57	14.58 49.10 27.70	18.03 58.75 26.89	6.03 16.42 7.86	12.23 41.07 17.94
GRAND TOTAL	86.96	48.81	68.20	15,385	4720	20105	25.90	7.97	16.95	23.60	8.25	15.14

Source: Census of Canada 1971.

^aWith reference to the week May 24-31, 1971, includes all persons 15 years and over who were in any of the following categories

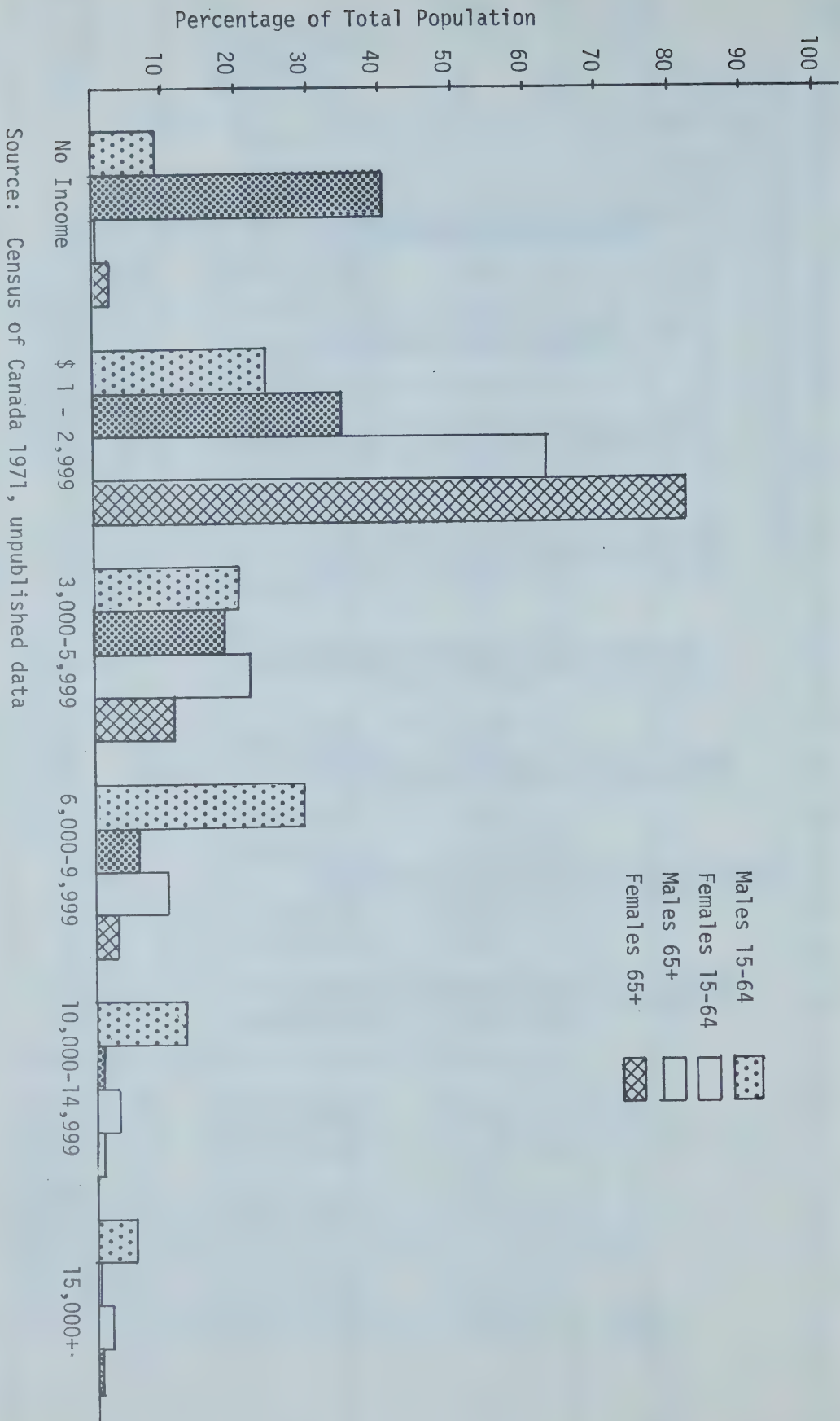
- worked for pay or profit
- worked without pay in family farm or business
- looked for work
- with job but temporarily laid off
- with job but temporarily absent from work

^bParticipation Rate: the percentage of the total population of that age group that was included in the labor force as defined above in "a"

^cThis urban category includes only Lethbridge.

^dPopulation centers of less than 1000 population.

FIGURE 5 COMPARISON OF INCOMES OF PERSONS AGED 15 - 64 AND 65+ BY SEX, ALBERTA, 1970 *



* Includes income from all sources in 1970: wages and salaries; business or professional practice; farm operations; family and youth allowances; government old age pensions; other government payments, retirement pensions from previous employment; bond and deposit interest and dividends, other investment sources; and other sources.

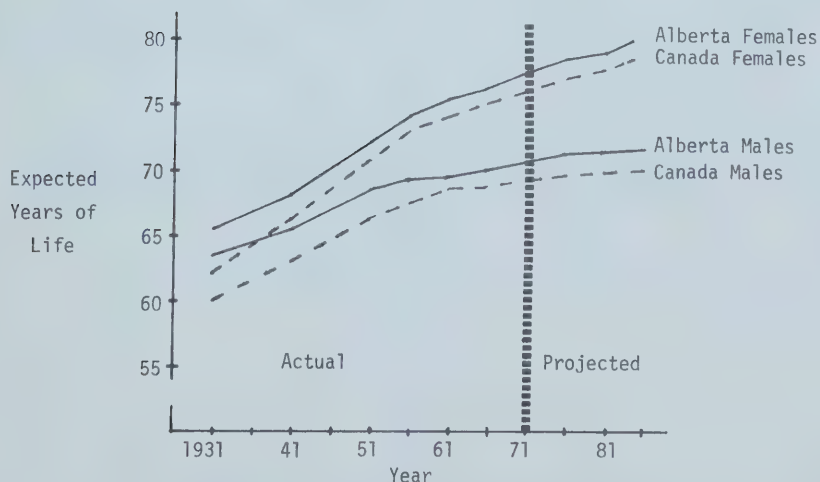
TABLE 9
AVERAGE LIFE EXPECTANCY AT SELECTED AGES BY SEX,
ALBERTA, ACTUAL 1931-1971 AND PROJECTED 1976-1986

Year	Alberta		Canada	
	Males	Females	Males	Females
At Birth				
Actual:				
1931	63.5 ^a	65.5 ^a	60.0	62.1
1941	65.4 ^a	68.2 ^a	63.0	66.3
1951	68.4 ^a	72.3 ^a	66.3	70.8
1956	69.3 ^a	74.2 ^a	67.6	72.9
1961	69.5	75.5	68.4	74.2
1966	70.1	76.2	68.8	75.2
1971	70.8	77.5	69.2	76.1
Projected:				
1976	71.3	78.4	69.7	77.0
1981	71.5	79.1	69.9	77.7
1986	71.8	79.8	70.1	78.4
At One Year				
1931	67.2 ^a	68.3 ^a	64.7	65.7
1941	68.0 ^a	70.2 ^a	66.1	68.7
1951	69.9 ^a	73.4 ^a	68.3	72.3
1956	70.5 ^a	75.1 ^a	69.0	74.0
1961	70.7	76.2	69.5	75.0
1966	70.8	70.8	69.5	75.7
At Sixty Years				
1931	17.1 ^a	18.0 ^a	16.3	17.2
1941	16.8 ^a	18.3 ^a	16.1	17.6
1951	17.3 ^a	19.3 ^a	16.5	18.6
1956	17.7 ^a	21.0 ^a	16.7	19.3
1961	17.5	20.9	16.5	19.9
1966	17.8	21.3	16.8	20.6

Sources: Vital Statistics Annual Report 1972; M.V. George and K.S. Gnanasekaran, Population and Labor Force Projections for Alberta, 1971-2001, and K.S. Gnanasekaran, Mortality Projections for Canada and Provinces 1950-1990.

^aIncludes all three Prairie Provinces.

FIGURE 6 AVERAGE LIFE EXPECTANCY AT BIRTH BY SEX,
ALBERTA AND CANADA, 1931 - 1986 *



Source: Vital Statistics Annual Report 1972; M.V. George and K.S. Gnanasekaran, Population and Labor Force Projections for Alberta, 1971-2001; and K.S. Gnanasekaran, Mortality Projections for Canada and the Provinces, 1950-1990

* Alberta data includes rates for all three prairie provinces for 1931 - 1956

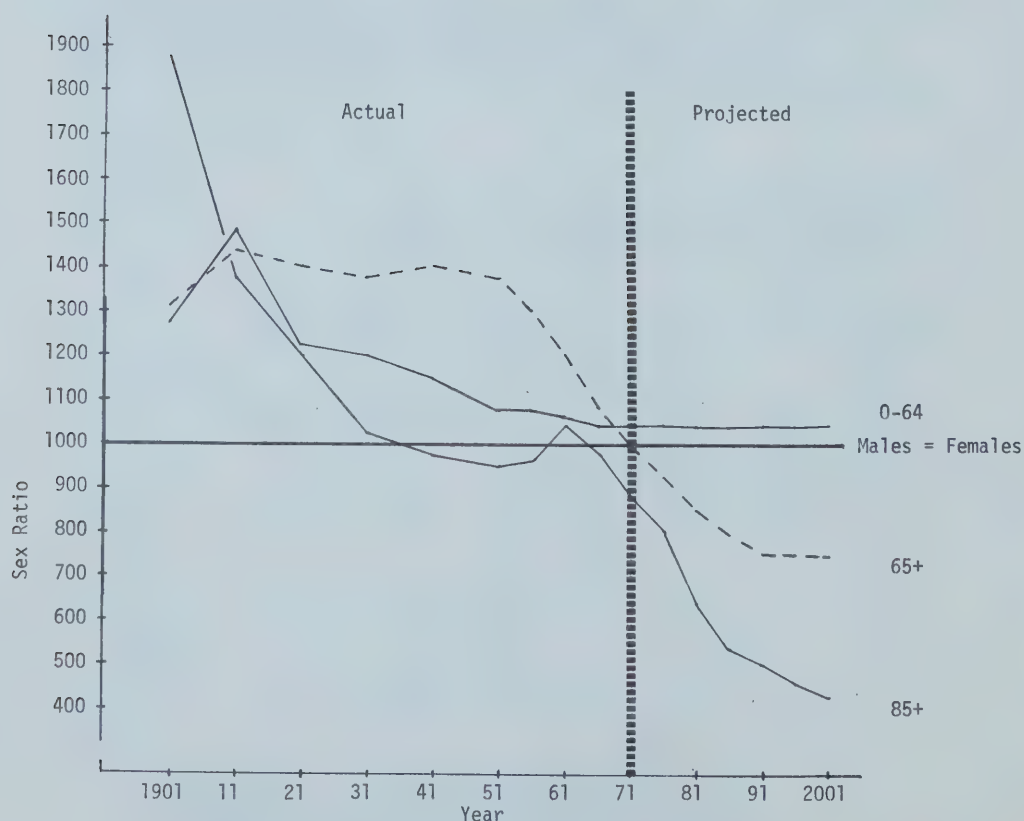
TABLE 10 . ACTUAL AND PROJECTED SEX RATIOS FOR THE ALBERTA
POPULATION, 1901 - 2001*

Year	Under 65 Years	65 Years & Over	85 Years & Over
Actual:			
1901	1,280	1,316	1,870
1911	1,488	1,437	1,372
1921	1,222	1,395	1,198
1931	1,202	1,374	1,020
1941	1,142	1,400	976
1951	1,082	1,374	946
1956	1,075	1,309	962
1961	1,064	1,208	1,039
1966	1,038	1,084	979
1971	1,037	1,004	883
Projected:			
1976	1,036	926	803
1981	1,037	852	642
1986	1,039	791	538
1991	1,041	751	500
1996	1,040	745	459
2001	1,039	739	423

Sources: Censuses of Canada 1901 - 1971; and Population Projections for Canada and the Provinces, 1972 - 2001, Statistics Canada, Cat. No. 91-514 Occasional (B Series).

*Sex ratio = males per 1,000 females.

FIGURE 7 SEX RATIOS BY AGE GROUPS, ALBERTA, 1901 - 2001



Source: Censuses of Canada 1901-71, and Population Projections for Canada and the Provinces, 1972-2001, Statistics Canada, Catalogue No. 91-514 Occasional (B series)

* Sex ratio = males per 1,000 females

TABLE 11 POPULATION 65 YEARS AND OVER BY
MARITAL STATUS AND SEX, ALBERTA, 1971

Marital Status	Alberta Population 15-64 Years %	Alberta Population 65+ Years # %	Canadian Population 65+ Years %
MALES			
Single	32.76	7,480 12.58	10.60
Married ^a	64.84	41,945 70.53	71.82
Widowed	0.77	9,085 15.28	16.66
Divorced	1.63	960 1.61	0.92
TOTAL	100.00	59,470 100.00	100.00
FEMALES			
Single	24.01	2,780 4.69	10.68
Married ^a	70.02	25,270 42.65	39.17
Widowed	3.63	30,540 51.54	49.41
Divorced	2.34	660 1.12	0.74
TOTAL	100.00	59,250 100.00	100.00
BOTH SEXES			
Single	28.45	10,260 8.64	10.64
Married ^a	67.39	67,215 56.62	53.81
Widowed	2.18	39,625 33.38	34.73
Divorced	1.98	1,620 1.36	0.82
TOTAL	100.00	118,720 100.00	100.00

Source: Census of Canada 1971, Cat. No. 92-730.

^aIncludes separated persons.

TABLE 12 HOUSEHOLD AND FAMILY STATUS OF POPULATION
65 YEARS AND OVER, ALBERTA, 1971

Household and Family Status ^a	Males		Females		Both Sexes	
	#	%	#	%	#	%
Primary Families						
Head	37,505	64.0	3,195	5.5	40,700	34.8
Spouse	n/a	n/a	21,125	36.2	21,125	18.1
TOTAL	37,505	64.0	34,320	41.7	61,825	52.9
Secondary Families						
Head	1,280	2.2	95	0.2	1,375	1.1
Spouse	n/a	n/a	955	1.6	955	0.9
TOTAL	1,280	2.2	1,050	1.8	2,330	2.0
Not in Families						
Household Head ^b	11,180	19.1	19,130	32.8	30,305	25.9
Relative of Head	2,515	4.3	6,280	10.8	8,790	7.5
Lodger	2,360	4.0	1,810	3.1	4,175	3.6
Employee/Partner of Head	175	0.3	565	1.0	740	0.6
Inmate of Institution ^c	3,600	6.1	5,190	8.8	8,795	7.5
TOTAL	19,830	33.8	32,975	56.5	52,805	45.1
TOTAL	58,615	100.0	58,345	100.0	116,960	100.0

Source: Census of Canada 1971.

^aPrimary Family - consists of a husband and/or wife, with/without children who have never been married regardless of age, when the head of the family is also the head of the household.

Secondary Family - consists of a husband and/or wife, with/without children who have never been married regardless of age, where the head of the family is not the head of the household. Secondary families include three types: (a) a related family - for example a retired father and mother living with their son's family (the son being the head of the household); (b) a lodging family - for example, a retired man and his wife living as lodgers with another family (the head of the other family being the head of the household); and (c) an other non-related family - for example, an employee and his wife/child living with his boss' family (where the boss is the head of the household).

Not in Families - households where the members are either not related (for example, lodgers, partners, inmates) or are related but not in a husband-wife or parent-unmarried child relationship (for example, a woman and her granddaughter, or two sisters).

^bOf these persons, 9,415 males and 16,325 females lived alone (16.1 per cent and 28.0 per cent of their total 65+ populations, respectively).

^cIncludes persons who have been in hospital more than six months, and all persons in nursing homes, sanatoria, mental hospitals, homes for the aged, penitentiaries, or other institutions.

TABLE 13 POPULATION 65 YEARS AND OVER BY ETHNIC GROUP,
ALBERTA AND CANADA, 1971

Ethnic Group	Alberta Population 65+ Years		Canadian Population 65+ Years
	#	%	%
British Isles	58,095	48.99	53.61
French	5,320	4.99	22.68
German	14,480	12.21	5.58
Italian	1,055	0.89	1.66
Jewish	760	0.64	1.93
Netherlands	2,420	2.04	1.19
Polish	3,730	3.15	1.64
Scandinavian	9,550	8.05	2.28
Ukrainian	11,540	9.73	3.15
Asian groups	1,680	1.42	0.93
Indian & Eskimo	1,825	1.54	0.72
Other & Unknown	8,125	6.85	4.63
TOTAL	118,580	100.00	100.00

Source: Census of Canada 1971.

TABLE 14 LANGUAGE MOST OFTEN SPOKEN AT HOME,
POPULATION 65 YEARS AND OVER, ALBERTA, 1971

Language	Population 65 Years and Over		Total Alberta Population
	#	%	%
English	93,175	78.56	90.79
French	2,535	2.14	1.39
Chinese/Japanese	1,220	1.03	0.58
German	4,985	4.20	1.80
Indian/Eskimo	1,485	1.25	1.35
Italian	405	0.34	0.63
Netherlands	625	0.53	0.32
Polish	1,410	1.19	0.31
Scandinavian	365	0.31	0.08
Ukrainian	9,505	8.02	1.67
Yiddish	150	0.13	0.02
Other	2,730	2.30	1.06
TOTAL	118,590	100.00	100.00

Source: Census of Canada 1971

TABLE 15 UTILIZATION OF MEDICAL SERVICES PER 1,000 INSURED PERSONS,
BY AGE AND SEX, ALBERTA, JULY 1, 1973 - JUNE 30, 1974

Age Group	Number of Medical Services Utilized		Resulting Amounts Paid by A.H.C.I.C.	
	#/1000	% of Total Services	\$/1000	% of Total \$
Males				
0-14	4,849	10.73	\$ 38,730	9.75
15-44	4,379	15.04	39,014	15.25
45-64	7,501	9.36	68,845	9.79
65+	12,757	6.75	105,869	6.38
TOTAL	5,641	41.88	\$ 48,715	41.17
Females				
0-14	4,580	9.67	36,025	8.65
15-44	8,515 ^a	28.66	81,836 ^a	31.34
45-64	9,898	12.20	88,082	12.35
65+	13,654	7.59	102,549	6.49
TOTAL	7,998	58.12	\$ 71,136	58.83
Both Sexes				
0-14	4,718	20.40	37,409	18.40
15-44	6,426	43.70	60,210	46.59
45-64	8,692	21.56	78,401	22.14
65+	13,216	14.34	104,169	12.87
TOTAL	6,807	100.00	\$ 59,805	100.00

Source: Alberta Health Care Insurance Commission Annual Report for the year ending June 30, 1974.

^aIncludes obstetrics.

TABLE 16 UTILIZATION OF MEDICAL SERVICES PER 1,000 INSURED PERSONS BY TYPE OF SERVICE, PERSONS 65 YEARS AND OVER, ALBERTA, JULY 1, 1973 - JUNE 30, 1974

Type of Service	Number of Services per 1,000 Persons				Ratio of Services per 1,000 Persons 65+ : Total Population	
	65 Years and Over		Total Population		Males	Females
	Males	Females	Males	Females		
Consultations	336	293	144	186	2.33	1.58
Office Visits	3,397	3,781	2,215	3,190	1.53	1.19
Hospital Visits	4,734	4,132	948	949	4.99	4.35
House Visits	896	1,390	191	231	4.69	6.02
Major Surgery	129	102	60	76	2.15	1.34
Minor Surgery	67	62	97	76	0.69	0.72
Surgical Assists	84	71	28	46	3.00	1.54
Obstetrical Services	-	-	-	39	-	-
Anaesthesia	222	161	106	154	2.09	1.05
Diagnostic Radiology	412	463	294	327	1.40	1.42
Pathology Services	1,763	2,435	1,000	1,982	1.76	1.23
Other Services	717	764	558	742	1.28	1.03
All Services	12,757	13,654	5,641	7,998	2.26	1.71

Source: Alberta Health Care Insurance Commission Annual Report for the year ending June 30, 1974

TABLE 17 UTILIZATION OF GENERAL HOSPITALS
BY AGE AND SEX, FOR ALBERTANS, 1972*

Age Group	Patient Days/1000 Population			Separations/1000 Population ^b			Mean Hospital Stay (in days)		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
0 - 14	1194.4	1008.5	1103.5	172.9	149.5	161.5	6.91	6.75	6.83
15 - 44	948.5	1332.8	1136.8	123.9	194.2	158.3	7.66	6.86	7.18
45 - 64	2764.1	2728.6	2746.5	237.5	260.0	248.6	11.64	10.50	11.05
65 and over	8205.1	7138.8	7669.2	512.0	430.9	471.3	16.03	16.57	16.27
Obstetrics ^a	-	297.8	146.3	-	53.3	26.2	-	5.59	5.59
ALL AGES	1854.5	2207.3	2027.9	186.4	262.9	224.0	9.95	8.40	9.04

Source: Alberta Hospital Services Commission.

* Includes all active treatment hospitalization of Albertans, regardless of place of occurrence, excluding newborns.

^a Obstetric rates are calculated on a total population base as opposed to the population in an age-sex specific group.

^b Separations is synonymous with cases or discharges.

TABLE 18 CURRENT LONG-TERM INSTITUTIONAL CARE OF
PERSONS 65 YEARS AND OVER, ALBERTA

Institutional Type	Capacity	Occupancy	% of Clientele 65+ Years	Population 65+ Years	% of Total Elderly
Auxiliary Hospitals	2,706 ^a	94.8 ^e	62.1 ^j	1,593	
Nursing Homes	6,869 ^b	97.8 ^f	91.4 ^f	6,140	
Psychiatric Hospitals:					
Edmonton (Oliver)	212 ^c	85.6 ^g	-	181	
Ponoka	202 ^c	93.7 ^g	-	189	
Homes for Special Care	-	-	-	1,506	
TOTAL	-	-	-	9,609	7.48
Senior Citizens' Lodges	4,347 ^d	100.0 ^h	100.0	4,347	
GRAND TOTAL	-	-	-	13,956	10.87

Data Sources: 1) Alberta Hospital Services Commission, Alberta Social Services and Community Health, and Alberta Housing Corporation.
2) Population 65 years and over as of June 1, 1974, Statistics Canada projections (128,400 persons).

^a As of August 1975, and excluding Henwood Rehabilitation Center.

^b As of August 1975.

^c Number of geriatric beds as of March 31, 1975.

^d As of October 11, 1974.

^e Calculated from average daily patient count for 1974.

^f As of June 30, 1975.

^g As of March 31, 1975.

^h Assumed.

^j As of November 1974.

NOTE: Excludes all elderly persons in active treatment hospitals.

TABLE 19 ESTIMATE OF AGE DISTRIBUTION OF NURSING HOME
PATIENTS, ALBERTA, AS OF JUNE 30, 1975*

Age Group	Patients in Alberta Nursing Homes	
	#	% of Total
Under 50	103	2.2
50 - 59	161	3.4
60 - 64	1139	3.0
65 - 69	246	5.3
70 - 74	395	8.5
75 - 79	662	14.2
80 - 84	1029	22.0
85 - 89	1101	23.6
90 - 94	669	14.3
95+	165	3.5
TOTAL	4670	100.0
Average Age	80.3	
Median Age	83.2	

Source: Alberta Hospital Services Commission, unpublished data.
*Excludes 2045 patients for whom age was not recorded. These persons are believed to be all over the age of 65 years.

TABLE 20 NURSING HOME PATIENTS BY TYPE OF CARE REQUIRED,
BY REGION, ALBERTA AS OF OCTOBER 16, 1974

Region	Number of Nursing Homes in Region	Type of Care Required ^a										Total	
		Type 1		Type 2		Type 3		Type 4		Type 5			
		#	%	#	%	#	%	#	%	#	%	#	%
Peace River Region	6	172	51.2	117	34.8	31	9.2	16	4.8	-	-	336	100.0
Edmonton Region	22	427	32.2	543	40.9	268	20.2	71	5.3	19	1.4	1328	100.0
Edmonton City	10	338	22.4	898	59.5	251	16.6	6	0.4	16	1.1	1509	100.0
Red Deer Region	4	55	20.0	155	56.4	61	22.2	4	1.5	-	-	275	100.0
Calgary Region	4	96	47.1	80	39.2	26	12.7	2	1.0	-	-	204	100.0
Calgary City	9	453	34.6	749	57.3	96	7.3	7	0.5	3	0.2	1308	100.0
Lethbridge Region	4	139	47.6	99	33.9	7	2.4	-	-	47	16.1	292	100.0
Medicine Hat Region	3	28	10.1	232	83.5	15	5.4	1	0.4	2	0.7	278	100.0
TOTAL	62	1708	30.9	2873	52.0	755	13.7	107	1.9	87	1.6	5530	100.0

^aTypes of Care:

Type 1 - patient is ambulant or independently mobile, but has decreased physical and/or mental faculties and requires primarily supervision and/or assistance with activities of daily living and provision of social and recreational services for psycho-social needs.

Type 2 - patient is a relatively stabilized long-stay chronically ill or functionally disabled person who has reached the limit of his recovery, and has little need for diagnostic or therapeutic services but requires 24-hour care.

Type 3 - patient is chronically ill (acute phase of illness has passed), may not be stabilized, may have limited potential for rehabilitation, and requires a range of therapeutic services on a long-term basis.

Type 4 - patient has a relatively stable disability requiring a specialized rehabilitation program to restore or improve functional ability. Maximum benefits of care are expected within a period of several months.

Type 5 - patient is in an acute or immediate convalescent stage of illness requiring care of relatively short duration.

Source: Alberta Hospital Association, Provincial Patient Census as of October 16, 1974.

TABLE 21 SELECTED STATISTICS FOR THE CALGARY
AND EDMONTON HOME CARE PROGRAMS, 1974/75

	Calgary	Edmonton
Patients carried from 1973/74	41	66
Admissions	527	639
Total patients during 1974/75	568	705
Discharges	525	479
Patients carried into 1975/76	43	226
Percentage of caseload 65+ years	24.0%	63.2%
Per diem cost	\$8.68	\$4.25
Per patient cost	\$192.68	\$329.75
Total program expenditures	\$109,415.00	\$232,477.00 ^a
Total patient days of care	12,597	54,700
Mean length of stay on program (days)	22.2	85.6

Source: Calgary and Edmonton Home Care Programs Annual Reports for 1974/75.

^aDoes not account for \$9893 recovered from some patients by application of a sliding scale user fee-for service.

TABLE 22 INCOME SECURITY PROGRAM STATISTICS, ALBERTA,
AUGUST 1975, JANUARY 1976

	August 1975		January 1976
	#	%	\$ Monthly Rates ^a
OLD AGE SECURITY	130,868	100.0	
Single Rate			132.90
Married Rate			132.90
GUARANTEED INCOME SUPPLEMENT			
Single Rate			93.22
Partial	21,224	16.2	57.2
Maximum	18,657	14.3	
Married Rate			
Partial	23,831	18.2	
Maximum	11,155	8.5	82.78
ALBERTA ASSURED INCOME PLAN			
Single Rate	40,161	30.7	57.2
Married Rate			
One Recipient	8,074	6.2	
Both Recipients	26,629	20.3	

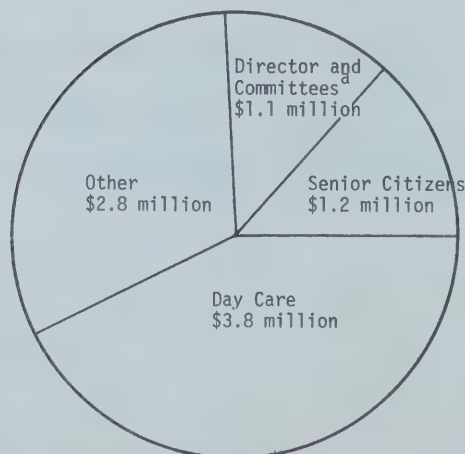
Source: Supplies and Services, National Health and Welfare

^a a married couple, both pensioners, receives \$262.88 per month;
a married couple, one pensioner, receives \$271.13.

TABLE 23 PROJECTS FUNDED THROUGH THE SENIOR CITIZENS COMMUNITY
SERVICE PROGRAM OF PREVENTIVE SOCIAL SERVICES,
AS OF OCTOBER 1975

<u>SENIOR CENTRES/DROP-IN CENTRES</u>		<u>HOME SUPPORT SERVICES</u>	
<u>Edmonton</u>	Society for the Retired, also Information Service Strathcona Place Operation Friendship	<u>Edmonton</u>	Edmonton Home Care (includes Meals- on Wheels) (75%) Edmonton Home Services for Seniors
<u>Calgary</u>	Victoria Pioneers Senior Citizens Central Council, also Information Service Confederation Park Golden Age Club Inglewood Silver Threads	<u>Calgary</u>	Project Home Help Calgary Family Services Homemakers (35%) Meals-on-Wheels
<u>Other Areas</u>	Barrhead Drop-in Bonnyville Drop-in Camrose Drop-down Buffalo Lake Drop-in Claresholm Drop-in Granum Drop-in Lethbridge Golden Mile Centre Drumheller Pioneer Trail Society Medicine Hat Senior Services Peace River Senior Citizens Centre Hughenden Golden Circle Provost Senior Citizen Centre Red Deer Downtown House St. Paul Senior Citizens Vermilion Senior Citizens Centre Paradise Valley Senior Citizens Centre Lloydminster Senior Citizens Centre Kitscoty Senior Citizen Centre Dewberry Senior Citizen Centre Marwayne Senior Citizen Centre Wetaskiwin Senior Citizen Centre Stavelly Chauvin Senior Citizen Centre	<u>Other Areas</u>	Athabasca Volunteers (80%) Athabasca Homemakers (55%) Camrose Homemaker (20%) Camrose Meals-on-Wheels (80%) Coaldale Home Care (Barons-Eureka) Elk Point Meals-on-Wheels Lac La Biche Homemaker Lacombe Home Help Leduc County Meals-on-Wheels Leduc County Homemakers (75%) Leduc Town Homemakers (50%) Leduc Town Meals-on-Wheels Lethbridge Meals-on-Wheels Lethbridge Homemakers (18%) Home Help (Lethbridge) Red Deer Meals-on-Wheels St. Albert Meals-on-Wheels Stettler Family Services (20%) Lloydminster Meals-on-Wheels Vermilion Meals-on-Wheels Vermilion Homemaker (10%) Lloydminster Homemaker (35%)
<u>OTHER PROJECTS</u>			
<u>Calgary</u>	Hillhurst Sunnyside Bowmont Senior Citizens Worker		
<u>Other Areas</u>	High Prairie Senior Citizens Coordinator Information Lethbridge (30%) Fort McMurray Senior Citizens Project		

FIGURE 8 DISTRIBUTION OF PREVENTIVE SOCIAL SERVICE
FUNDS, ALBERTA, 1975 - 76



^a Many of the P.S.S. directors spend part of their time working with senior citizens groups.

FAMILY PLANNING PROGRAMS IN BRITAIN, WEST GERMANY, DENMARK AND SWEDEN, WITH IMPLICATIONS FOR CANADA

Dr. E.S.O. Smith*

INTRODUCTION

The author was awarded a WHO Travel Fellowship to study family planning and venereal disease control programs in Britain, West Germany, Denmark and Sweden. He spent two weeks in each country between December 1974 and February 1975. This report covers only the family planning aspects of the tour.

For a proper appreciation of family planning programs it is necessary to have some background information on vital statistics, particularly those pertaining to births, abortions and illegitimacy. It is also necessary to know something about each country's legislation, not only on family planning itself but also on abortion and other topics which have a bearing on family planning.

VITAL STATISTICS

The vital statistics relevant to family planning, covering population, live births, illegitimate or out-of-wedlock births and abortions during 1973, including those for Canada, are summarized in Table 1, and the birth rate trends for the period 1968 to 1973 are shown in Table 2. Since vital statistics for England and Wales are published separately from and were more readily available than those for Scotland and Northern Ireland, data for England and Wales have been used in place of those for Britain as a whole.

In England and Wales the birth rate is falling and the ratio of abortions to live births is rising; however, more than one-third of the abortions were performed on non-residents. The overall illegitimacy rate has shown very little change since 1967, but the rate for women under 20 years of age has been steadily increasing.

In West Germany there are nearly four million alien workers and their families, mostly from Turkey, Yugoslavia, Italy, Greece and Spain, who account for 6.5 per cent of the total population. While the general birth rate has been falling rapidly since 1964, the birth rate among aliens has been climbing sharply; in 1973 aliens accounted for 15.9 per cent of all live births. The proportion of illegitimate births is fairly constant.

In Denmark the birth rate is gradually falling and the ratio of abortions

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to live births is rising; because of a change in legislation, this rise has been particularly evident since the middle of 1973. The rate for out-of-wedlock births is increasing, but these children are not regarded as illegitimate and in the majority of cases the unmarried parents continue to live together as a family unit.

In Sweden the birth rate appears to have levelled off in the last four or five years after falling steadily. The abortion ratio has been rising throughout the last 15 years, and with increased rapidity in the last five years during which anticipation of a change in the law seems to have led to a more liberal interpretation of the existing law. The proportion of children born out of wedlock has been steadily increasing since, as in Denmark, these children are not regarded as illegitimate and in about two-thirds of cases the unmarried parents continue to live together as a family unit.

In Canada the birth rate has been falling and the ratio of abortions to live births has been rising. The illegitimacy rate has shown a slight downward trend since reaching a peak in 1970.

LEGISLATION ON ABORTION

In Britain the Abortion Act of 1967 considerably broadened the grounds for abortion but stopped short of abortion on demand, leaving the final decision to the individual doctor. In 1971 the government appointed a Committee on the Working of the Abortion Act under the chairmanship of the Honourable Mrs. Justice Lane. The main conclusions of the Lane Report, published in April 1974, were that counselling is essential for all women seeking abortion; that abortion should be part of medical care; that residents should enjoy greater access to abortion, and not be obliged to seek abortion outside the National Health Service; and that there is a need for research into contraception and unwanted pregnancy. It was also recommended in the Lane Report that the grounds for abortion should not be changed; that physicians, without restriction on qualifications, should continue to make abortion decisions without statutory panels or referees; that abortion should be performed if possible before the 12th week of pregnancy, and always before the 24th week (instead of the 28th week, as permitted by the Abortion Act); and that non-residents should continue to have access to abortion in Britain as long as the arrangement was not abused.

Abortion has hitherto been illegal in the Federal Republic of Germany

and, despite the passage of a Bill to amend the Criminal Code, it still is. In June 1974 the Bundestag (Parliament) passed with an absolute majority a Bill permitting a physician to terminate a pregnancy of up to 12 weeks solely upon a woman's consent, and a pregnancy of up to 22 weeks upon the medical certification of serious risk to a woman's life or health. The day after the new law was proclaimed the Christian-Democratic Government of the Land (Province) of Baden-Württemberg applied to the Federal Constitutional Court for an injunction. The injunction was granted, and in February 1975 the Court announced that since the law was based on the time-limit principle it was incompatible with an Article in the Constitution which guarantees the right to life. In the meantime realistic estimates assume that between 20 and 30 per cent of all pregnancies are being terminated prematurely by illegal abortion.

In Denmark abortion has been the subject of special legislation since 1937, when it was permitted for medical and socio-medical indications involving serious danger to a woman's life or health, for ethical indications such as rape or incest, and for hereditary indications associated with the risk of insanity, mental deficiency or incurable abnormality. A second Abortion Act in 1956 extended the hereditary indications to include risk of foetal injury (e.g. from rubella or drugs), and added a defect indication to cover the situation where a woman by reason of serious physical or mental defect was incapable of caring for her child. A third Abortion Act in 1970 made it possible for a woman to obtain abortion during the first 12 weeks of pregnancy if she has attained the age of 38 or if she has given birth to four children who were still under 18 and living at home; abortion was also permitted if the woman was too young or immature to care for her child, or if the strain of pregnancy, delivery and care of the child was deemed to be excessive. The most recent Abortion Act came into effect in July 1973, and provides for free abortion on demand up to the 12th week of pregnancy without regard to age; special permission is required for an abortion after the 12th week, and parental consent for abortion is required in the case of a girl under 18.

The situation in Sweden is similar. Abortion was first permitted in 1938 on certain medical, eugenic and humanitarian grounds. Socio-medical reasons were recognized in 1946, and abortion on the grounds of probable foetal damage became legal in 1963. Subject to these conditions, and provided pregnancy had not progressed beyond the 20th week, an abortion could be

authorized either by two physicians or by a specially appointed committee of the National Board of Health and Welfare. The latest legislation, which became effective the 1st January 1975, makes free abortion on demand available up to the end of the 12th week of pregnancy.

In Canada the Criminal Code was amended in 1969 to provide a standard procedure for legally authorizing a therapeutic abortion. The law permits, but does not oblige, any accredited hospital to establish a therapeutic abortion committee. An abortion may only be performed with the prior approval of this committee, which must be satisfied that continuation of the pregnancy would be likely to endanger the woman's life or health.

LEGISLATION ON FAMILY PLANNING

In 1930 the Ministry of Health for England and Wales issued a circular to Local Health Authorities permitting them to provide birth control advice to any woman for whom a further pregnancy would be detrimental to health. The National Health Service (Family Planning) Act of 1967 permitted Local Health Authorities to give birth control advice to social as well as medical cases, without regard to marital status, using voluntary organizations such as the Family Planning Association as their agents if they so wished. In 1970 it became mandatory for family planning clinics to offer services to unmarried patients. In 1972 an amendment to the National Health Service (Family Planning) Act authorized Local Health Authorities to provide vasectomies without charge. Finally the National Health Service Reorganization Act of 1973 made family planning part of the National Health Service effective the 1st April 1974, and at this point the National Health Service (Family Planning) Act of 1967 and its amendment of 1972 were repealed. Just before the effective date of the new legislation the Secretary of State for Social Services, Mrs. Barbara Castle, announced in the House of Commons that family planning would be free at NHS clinics for all who asked for it, irrespective of age and marital status, and that there would be no prescription charge for family planning supplies obtained from NHS clinics and hospitals.

In Western Germany contraception is legal, but hormonal contraceptives may only be issued on medical prescription, and there is no law establishing the right to free contraceptive advice. Male and female sterilization are legal, but the circumstances in which sterilization is performed are at the discretion of the individual physician.

In Denmark a revision of the Pregnancy Hygiene Act of 1966 provided for free pre-natal and post-natal care, and made it obligatory for the physician to discuss family planning at the final post-natal examination. The same Act gave to every person over the age of 15 years the right to seek contraceptive advice from a physician without parental consent. A law introducing compulsory sex education into all Danish schools, starting in grade 1, came into force on the 1st August 1971. Sterilization was formerly permitted only if there was a risk of transmitting a hereditary disease, if the applicant was unable to care for a child, or if his or her personal or family circumstances made it necessary to avoid more children. Since 1973, however, the law has permitted sterilization (vasectomy or tubal ligation) on request for any person who has attained the age of 25 years.

In Sweden contraceptive devices and the dissemination of knowledge about contraceptive methods were illegal until 1938. Sex education was introduced into Swedish public schools in 1944, and became compulsory for all children in 1956. As in Denmark, contraceptive advice may now be given to any person who has reached the age of 15 years without parental consent; in contradistinction to Denmark, however, the physician is actually forbidden to inform parents that a young person has approached him for advice. After an abortion, contraceptive counselling is obligatory. At the time of the author's visit to Sweden sterilization could only be performed with the permission of the National Board of Health and Welfare; applications for tubal ligation were usually approved, but vasectomy was prohibited except in very rare circumstances such as for eugenic reasons. In March 1975, however, the Government introduced a Bill proposing to legalize sterilization upon request for any man or woman over the age of 24 years.

In Canada until 1969 it was an offence against the Criminal Code either to disseminate birth control information or to sell contraceptives. The law had been largely ignored, however, not only by physicians who had been fitting diaphragms, inserting intra-uterine devices and prescribing oral contraceptives for many years, but also by pharmacists who had been making non-prescription contraceptives available to any person who asked for them.

OTHER LEGISLATION

In Britain the Family Law Reform Act, introduced in 1969, reduced the general age of majority from 21 to 18 years, but made it possible for any

person of 16 to consent to medical, surgical or dental treatment on his or her own behalf, without parental authorization. Under this legislation a 16-year-old is entitled to all the privileges of professional secrecy, and can decide what information, if any, shall be communicated to his or her parents. According to a legal opinion obtained by the Family Planning Association, a physician who gives contraceptive advice to a girl under the age of 16 is not considered to be aiding or abetting the offence of unlawful intercourse if he acts in good faith in protecting her against the potentially harmful effects of intercourse, but it is prudent for him to ask the patient for permission to inform her parents.

In Denmark legislation was introduced as long ago as 1763 making the father of an out-of-wedlock child liable to contribute to the support of the child, and in 1888 a law was enacted giving the mother the right to have the father's maintenance payment made in advance by the municipal authority. Current legislation, based on a 1937 Act concerning children born out of wedlock, as amended by the Legal Status of Children Act of 1960, ensures for a child born out of wedlock the same rights in relation to its parents as a child born in wedlock, including the right to use its father's name and the right to inherit; the father has a obligation to support the child until the age of 18 years and, if necessary, to contribute towards the cost of the child's education until the age of 24 years.

Sweden has similar legislation to that of Denmark on the father's responsibility for support of an out-of-wedlock child, except that a child who remains in school beyond the age of 18 years is entitled to continued support only until the age of 20 years. A law stipulating equal paternal inheritance rights for children born out of wedlock as for children born in wedlock was introduced in 1970.

In both Denmark and Sweden it is claimed that the paternity of out-of-wedlock children is successfully established in about 90 per cent of cases.

ORGANIZATIONS AND SERVICES - ENGLAND AND WALES

The organization primarily concerned with family planning in England and Wales is the Family Planning Association (FPA), whose objectives are:

- (1) to preserve and protect the mental and physical health of parents, young people and children and to prevent the poverty, hardship and distress of unwanted conception;
- (2) to educate the public in the field of procreation, contraception

and health, with particular reference to personal responsibility in sexual relationships;

- (3) to give medical advice and assistance in cases of involuntary sterility or of difficulties connected with the marriage relationship or sexual problems for which medical advice or treatment is appropriate;
- (4) to provide training for all members of the health team, sex education courses for FPA speakers and teachers, training for young volunteers to enable them to help their own age group, research into improved methods of delivering family planning services and collection and dissemination of information about government family planning services.

Prior to the 1st April 1974 the FPA was operating nearly one thousand clinics in England and Wales as agents of the Local Health Authorities (LHA's), but at the time of the author's visit these were rapidly being handed over to the LHA's themselves; the target date for handing over was the 1st April 1975, but it was doubtful whether the transfer of responsibility could be completed by then.

Family planning clinics are also operated by certain hospitals, and a few of these hospitals maintain special clinics to which patients with psycho-sexual problems can be referred.

As already indicated in the section on family planning legislation, contraceptives have been provided free of charge since the 1st April 1974 to persons attending NHS family planning clinics, clinics operated by the FPA on behalf of the NHS and clinics in hospitals.

It would appear that relatively few general practitioners offer family planning advice as part of their normal office practice, evidently because they consider it to be outside their contract of service. However, many general practitioners have taken family planning courses organized by various bodies such as the FPA, LHA's and universities in order to qualify for part-time appointments in family planning clinics. The FPA offers to physicians who demonstrate the necessary competence a certificate of proficiency which enjoys reciprocity with a certificate offered by the Joint Committee on Contraception of the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners.

ORGANIZATIONS AND SERVICES - WEST GERMANY

In West Germany the agency concerned with the organization of family planning services is called "Pro Familia". Like the FPA, it is a member of

the International Planned Parenthood Federation. Its objectives may be described in the following terms:

- (1) to influence government policy on family planning;
- (2) to publish and distribute literature about family planning for the information of the public;
- (3) to keep the news media properly informed;
- (4) to provide counselling on pregnancy, contraception and sexual problems;
- (5) to operate family planning clinics;
- (6) to organize conferences on family planning;
- (7) to organize courses for physicians and nurses;
- (8) to advise and collaborate with the government on its foreign aid project concerned with family planning in Tunisia.

Family planning advice is available free of charge at the clinics operated by "Pro Familia", but the organization has very limited resources and operates fewer than 80 clinics. Special efforts are being made to reach the families of alien workers, whose fertility is so high, and to overcome the very considerable language barrier which exists.

The educational efforts of Pro Familia are complemented by those of the federally-supported "Bundeszentrale für Gesundheitliche Aufklärung", whose extensive health education activities embrace sex education and family planning, and are accomplished not only by the publication of literature but also by the preparation and distribution of high quality anatomical models and other visual aids. This agency also publishes a superb sex education atlas in colour, for use in schools, which unfortunately in some parts of the country never succeeds in reaching the target population.

The Federal Ministry of Youth, Family and Health supports the principle of family planning through its publication of a brochure entitled "Every Child has a Right to be Wanted", and contributes financially towards the operating costs of certain "model clinics" established at its request by "Pro Familia".

Most of the family planning work in West Germany is evidently undertaken by private physicians, some of whom are strongly supportive of the efforts being made by "Pro Familia". Very little family planning is done routinely in gynaecological clinics, with the possible exception of those at university hospitals which often provide a service to female students.

ORGANIZATION AND SERVICES - DENMARK

In Denmark the counterpart of the FPA and "Pro Familia" is the Danish Family Planning Association, which is a member of the IPPF. Its objectives are:

- (1) to publish information and research on family planning and responsible parenthood;
- (2) to publish and distribute pamphlets aimed at particular age groups;
- (3) to organize courses in sex education for teachers and other professional groups;
- (4) to press for changes in legislation;
- (5) to sell contraceptives;
- (6) in a small way, to provide clinical facilities.

This agency has concentrated its efforts on educational activities and on influencing government policy rather than on providing clinical services, and in fact it operates only two clinics, at which the service is free.

Most of the clinical activity related to family planning is undertaken by Mother's Aid Centres, which are supported by municipal Social Welfare Departments. Their functions are:

- (1) to provide help and advice to families and single mothers before and after childbirth;
- (2) to provide financial assistance where necessary;
- (3) to assist single women with legal proceedings aimed at establishing paternal responsibility;
- (4) to provide temporary accommodation for unmarried mothers and their children;
- (5) to facilitate training and rehabilitation for unmarried mothers;
- (6) to assist women seeking abortion on demand in the first 12 weeks of pregnancy;
- (7) to provide contraceptive advice to persons who have attained the age of 15 years;
- (8) to act as intermediaries in arrangements for adoption.

Within the Mother's Aid system there are 32 clinics, at which advice is obtainable free of charge. Nor is there any charge for intra-uterine devices or diaphragms, but other contraceptives must be paid for. At these clinics there is an increasing tendency towards the use of IUD's, particularly the copper-T or copper-7.

Family planning services are also available from general practitioners, but the patient must then pay a fee; however, all or part of the fee may be

recoverable from medical insurance, depending upon the patient's income level.

ORGANIZATIONS AND SERVICES - SWEDEN

Sweden's representative in the IPPF is the Swedish Association for Sex Education, known as the RFSU, whose objectives are:

- (1) to improve sex education in schools;
- (2) to publish and distribute pamphlets and posters informing the public about family planning;
- (3) to organize courses and seminars for physicians, midwives, teachers and social workers;
- (4) to sponsor conferences, including international symposia;
- (5) to press for changes in legislation;
- (6) to sell contraceptives, particularly condoms;
- (7) to provide facilities for psycho-sexual counselling;
- (8) in a small way, to provide clinical facilities.

Like its Danish counterpart, this agency has devoted its attention to educational activities and attempts to influence government policy rather than to the provision of clinical services. It operates only two clinics (one in Stockholm and one in Göteborg), at which the services are free. The RFSU has an international reputation for the quality of its visual aids, which include anatomical models, but the feature which makes this organization unique is the fact that it derives two-thirds of its revenue from the sale of condoms.

The National Board of Health and Welfare, which is responsible for administering the legislation on abortion, aims through its health education activities to make the public aware that contraception is preferable to abortion. This government body, known as the HVUD, provides financial support for maternal health services, which operate family planning clinics, and complements the activities of the RFSU by arranging courses in family planning methods and counselling for midwives and social workers, and by serving as a resource agency for the sex education program in schools.

Family planning advice in Sweden is available free of charge at any of the 600 maternal health centres. Most of the family planning work at these centres, including the insertion of IUD's, is done by midwives; the choice of contraceptive pill is also made by midwives, but the prescription has to be signed by a physician before it is issued.

Very little family planning is done in gynaecological clinics, which are

disease-oriented, and where there is also a charge; and very little family planning advice is given by general practitioners, who are too busy, and who charge even more than hospital clinics.

The Stockholm School Board maintains a clinic for sexual problems which is staffed by a full-time gynaecologist. Students may telephone for an appointment, and may be excused from classes to visit the clinic. Contraceptive advice is offered without charge, and many girls avail themselves of this advice before entering into a sexual relationship for the first time. The School Boards in Göteborg and Uppsala provide a similar service.

ORGANIZATIONS AND SERVICES - CANADA

Organized family planning activities in Canada began with the opening of a clinic by the Planned Parenthood Society of Hamilton in 1932, followed by the establishment of a Parents' Information Bureau in Kitchener a year or two later and the operation of a home visiting service by the Family Planning Association of Winnipeg at about the same time. Subsequent developments were extremely slow, however, and it was not until 1961 that a Planned Parenthood Association was formed in Toronto.

In the meantime a movement to disseminate information about the basal body temperature method of conception control was started in 1955 by a small group in Quebec. This group, known as the Serena movement, later extended the scope of its teaching to include other methods of contraception.

In 1963 the formation of the Family Planning Federation of Canada provided an opportunity for local family planning associations to coordinate their activities.

Since 1969, when the Criminal Code was amended, several provincial governments have been actively encouraging the establishment of family planning clinics and/or counselling and referral services, and Health and Welfare Canada has made funds available to assist their development. However, the situation is different in every province, and even within certain provinces there is no uniform pattern.

While the public can now obtain information about family planning from most provincial health departments, city health departments and local health units as well as from local voluntary agencies, it would appear that most of the clinical activities in family planning in Canada are undertaken by private physicians.

IMPLICATIONS FOR CANADA

It is the author's opinion that Canada has much to learn from the European approach to family planning, and perhaps most of all from the Swedish system. Adapted to the Canadian scene, the features which are worth emulating may be summarized as follows:

- (1) Courses in family planning counselling and psycho-sexual counselling for physicians, nurses (particularly public health nurses) and social workers
- (2) Training in family planning methods for physicians
- (3) Training in family planning methods for nurses, with practical training in fitting of contraceptive devices for nurse-practitioners and nurses qualified in advanced practical obstetrics
- (4) Courses in family life education as a requirement for the certification of teachers
- (5) Courses in family life education for parents and couples (unmarried as well as married)
- (6) Teaching of family life education as an integral part of the basic school curriculum from kindergarten through grade 12
- (7) Emphasis in family life education on the preferability of contraception to abortion
- (8) Use of anatomical models for family life education in schools
- (9) Use of the term "out-of-wedlock" in place of "illegitimate" in all legislation and official documents
- (10) Legislation to enable unmarried mothers to claim support for out-of-wedlock children from provincial or municipal social services, and for the latter to recover some from the fathers concerned
- (11) Legislation to ensure rights of paternal inheritance for out-of-wedlock children
- (12) Legislation to recognize unmarried parents and their children as family units
- (13) Legislation to permit specially trained nurse practitioners and nurses qualified in advanced practical obstetrics to fit contraceptive devices
- (14) Legislation to permit physicians to prescribe contraceptives and/or fit contraceptive devices for sexually active 15-year-olds in need of protection without parental consent
- (15) Legislation to permit physicians and specially trained nurse practitioners and nurses qualified in advanced practical obstetrics to prescribe contraceptives and/or fit contraceptive devices for 16-year-olds without parental consent
- (16) Legislation to permit 16-year-olds to apply for and consent to their own abortion

- (17) An obligation upon physicians to discuss family planning after childbirth or abortion
- (18) Establishment of family planning information, education, counselling and referral services by health units and city health departments in collaboration with local family planning associations in communities with a population in excess of 5,000
- (19) Establishment of family planning clinics by health units and city health departments in collaboration with local family planning associations in cities with a population in excess of 25,000
- (20) Establishment of psycho-sexual counselling clinics in association with family planning clinics in major cities
- (21) On a trial basis, establishment of gynaecological clinics in relation to the school system in selected major cities.

Many of the proposals implied by this list represent a radical departure from tradition, and it is recognized that public attitudes are slow to change. Moreover, since many Canadians have become accustomed to depending exclusively upon their private physicians for family planning advice, and for the most part seem to be satisfied with this arrangement, it is unlikely that their habits would change very rapidly even if public clinics were established in greater numbers. It is anticipated that clinics might become increasingly popular with young people as long as they were located in major centres of population where there could be a reasonable assurance of anonymity.

TABLE 1. POPULATION, LIVE BIRTHS, ILLEGITIMATE BIRTHS AND LEGAL ABORTIONS IN ENGLAND AND WALES, WEST GERMANY, DENMARK, SWEDEN AND CANADA, 1973

Country	Population (thousands)	Live Births		Illegitimate Births*		Legal Abortions	
		Number	Rate/1000 Population	Number	Rate/100 Live Births	Number	Ratio/100 Live Births
England and Wales	49,175	676,000	13.7	58,100	8.6	169,362	25.1
West Germany	61,400	631,631	10.3	38,000	6.0	--	--
Denmark	5,000	75,000	15.0	10,500	14.0	25,000	33.3
Sweden	8,100	112,000	13.8	28,000	25.0	28,000	25.0
Canada	22,125	343,373	15.5	29,660	8.6	43,201	12.6

*In Denmark and Sweden these are referred to as out-of-wedlock births

TABLE 2. TRENDS IN BIRTH RATE IN ENGLAND AND WALES, WEST GERMANY, DENMARK, SWEDEN AND CANADA, 1968 - 1973

Country	Live Births per 1000 Population					
	1968	1969	1970	1971	1972	1973
England and Wales	16.9	16.4	16.1	16.0	14.8	13.7
West Germany	16.1	14.8	13.4	12.7	11.3	10.3
Denmark	15.3	15.3	15.3	15.2	15.2	15.0
Sweden	14.3	13.5	13.7	14.1	13.8	13.8
Canada	17.6	17.6	17.5	16.8	15.9	15.5

HIGHLIGHTS OF PUBLIC ASSISTANCE

Delaine McVey*

Table 1 presents the distribution of the public assistance caseload by reason for assistance for the quarter January - March 1975 and compares the distribution to that of the previous quarter. Ranking of the various reasons remains unchanged, with persons with dependent children comprising the largest proportion of the caseload (37.3 per cent). Persons sixty years of age or older constituted 21.1 per cent of total caseload, and those requiring assistance due to physical ill health or disability comprised 18.6 per cent. Employables increased from 11.0 per cent of the October - December 1974 caseload to 13.4 per cent this quarter.

Total caseload increased from an average 28,931 in the previous quarter to an average 30,550 in the January - March quarter, or 5.6 per cent. Employables experienced the greatest increase in the current quarter (29.5 per cent). Mental retardation and unsuited for employment as reasons for assistance continued to increase. However, these changes are primarily the result of changes in the coding system, and they are mainly transfers from other reasons for assistance. Persons with dependent children (primarily mothers) experienced a two per cent increase which reversed their trend in the two previous quarters. The mental ill health caseload decreased further by 0.4 per cent.

Figure 1 presents the provincial caseload by specific reason for assistance for the five-year period April 1970 to March 1975. This reflects the effects of a change to a priority system of assigning reasons for assistance in April 1973 and changes in reasons for assistance in March 1974.

Prior to April 1973, applicants were assigned a reason for assistance according to the primary reason as perceived by their social worker. Thus, a person 65 years old on assistance because of illness could have been coded as an "age" or "ill health" case according to their social worker's perception of the primary reason for seeking assistance.

In March 1973, social workers were given a ranking system for assigning reasons for assistance according to a specific order of priority. Thus, the

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65 year old in ill health was to be coded as an "age" case, since "age" cases ranked higher in priority than illness. The intent of adopting a priority system was to standardize coding methods used by social workers.

The following indicates by rank order the reasons for assistance in use at that time (see Glossary for definitions and determination of appropriate reason).

1. Age 60+
2. Mother with dependent children
3. Father with dependent children
4. Physical ill health
5. Mental ill health
6. Employed with insufficient income
7. Unemployed employables
8. Guardian Social Allowance

Substantial shifts occurred with the introduction of the priority system of assigning reasons for assistance. Increases in cases classified as "age" and "mother (or father) with dependent children" were balanced by decreases in "physical ill health," "mental ill health," "employed with insufficient income," and "unemployed employables."¹

The March 1974 changes in reasons for assistance combined mothers and fathers with dependent children into one category, persons with dependent children; unemployed employables and employed with insufficient income were combined as employables; mental ill health caseload was redefined as mental ill health or mental retardation; and a new reason for assistance, unsuited for employment, was introduced. The following indicates these reasons for assistance by their priority rank order (see Glossary for definitions).

1. Age 60+
2. Person with dependent children
3. Physical ill health/disability
4. Mental ill health
5. Mental retardation
6. Employables
7. Unsuited for employment
8. Guardian Social Allowance

Figure 1 illustrates the impact on total caseload of rising "person with dependent children" caseload, as well as the slowly downward trend of employable cases and their seasonal pattern, with caseloads higher during winter months and lower during the summer.

¹ For details, see the Quarterly Statistical Review of April - June 1973.

Figure 2 graphically presents the provincial caseload by sex and family status for the five years of April 1970 to March 1975. Biases due to variations in assigning reasons for assistance have no material effect on these categories. Thus, female family head caseload reflects persons with dependent children more closely than does Figure 1 for the period up to April 1973. Male family head caseload, and to a lesser extent, male single person caseload, reflect the seasonal pattern of Employables. However, the former category has a downward trend, while male single persons have an upward trend. Female single persons have a strong upward trend over the past four years.

Table 2 indicates the age-sex distribution of the caseload for the January - March 1975 quarter. The proportion of the caseload comprised of males increased to 36.6 per cent this quarter from 34.9 per cent in the October - December quarter. These were absolute increases from 10,090 to 11,179 males and from 19,007 to 19,371 females. Male caseload is greatest for those 60+ years of age. Females 20 - 24 constituted nearly 17 per cent of the total caseload. Except for females 50 - 54, 60 - 64, and 65+, all age groups for both sexes experienced absolute increases this quarter.

Table 3 indicates the distribution of caseloads for regional offices. The decreases indicated for some Edmonton and Calgary offices primarily reflect transfers made to other offices and are more than offset by overall increases: 6.5 per cent for total Calgary regional offices and 4.5 per cent for Edmonton. Of the other regional offices, only four experienced caseload decreases in the January - March quarter. Wainwright was the only regional office to have successive decreases for the two quarters. Two regional offices had percentage increases exceeding ten per cent. The greatest percentage increases were Grande Cache's 36.1 per cent, followed by Whitecourt's 21.4 per cent increase.

Table 4 indicates the employment status of cases by reason for assistance during the January to March 1975 quarter. Fifty-four per cent of employables are available for full-time work; over 22 per cent are already employed full-time; 14 per cent are undergoing education or training. The majority of persons with dependent children cases are required to care for children (73.8 per cent). However, ten per cent of persons with dependent children are seeking full-time work or employed full-time.

TABLE 1 DISTRIBUTION OF CASELOAD BY REASON FOR ASSISTANCE, ALBERTA
JANUARY - MARCH 1975

Reason for Assistance	Last Quarter's Average October-December 1974 #	%	January	February	March	Quarterly Average January-March 1975 #	%	Percentage Change Between Quarters
Age 60 +	6,355	21.97	6,398	6,430	6,490	6,440	21.08	1.34
Physical Ill Health/ Disability	5,455	18.85	5,611	5,670	5,730	5,670	18.56	3.94
Mental Ill Health	2,051	7.09	2,026	2,052	2,051	2,043	6.69	- 0.39
Mental Retardation	399	1.38	481	492	516	496	1.62	24.31
Unsuited for Employment	330	1.14	375	404	424	401	1.31	21.52
Person with Dependent Children	11,171	38.61	11,343	11,402	11,443	11,396	37.30	2.01
Employable	3,170	10.96	3,877	4,223	4,212	4,104	13.44	29.46
TOTAL	28,931	100.0	30,111	30,673	30,866	30,550	100.0	
Increase Rate Over Previous Month			2.85	1.87	0.63			
Increase Rate Over Previous Quarter	- 0.01							5.60

TABLE 2 AGE-SEX DISTRIBUTION OF CASELOAD, ALBERTA
JANUARY - MARCH 1975

AGE GROUP	MALES		FEMALES		BOTH SEXES	
	#	%	#	%	#	%
0-19	643	2.11	1455	4.76	2098	6.87
20-24	1093	3.58	2610	8.54	3703	12.12
25-29	1015	3.32	2571	8.42	3586	11.74
30-34	798	2.61	1970	6.45	2768	9.06
35-39	733	2.40	1746	5.71	2479	8.11
40-44	862	2.82	1577	5.16	2439	7.98
45-49	901	2.95	1395	4.57	2296	7.52
50-54	865	2.83	1364	4.46	2229	7.29
55-59	1064	3.48	1447	4.74	2511	8.22
60-64	1668	5.46	1896	6.21	3564	11.67
65 +	1537	5.03	1340	4.39	2877	9.42
TOTAL	11179	36.59	19371	63.41	30550	100.00

TABLE 3 REGIONAL DISTRIBUTION AND CHANGE IN CASELOAD, ALBERTA
JANUARY - MARCH 1975*

Regional Office	Last Quarter's Average October - December 1974		Quarterly Average January - March 1975		Percentage Change Over Last Quarter	Rank Order	
	#	%	#	%		Last Quarter	This Quarter
Edmonton North	4,759	16.45	4,988	16.33	4.81	1	1
Calgary South	3,902	13.49	3,438	11.25	- 11.89	2	2
Calgary North	2,708	9.36	2,533	8.29	- 6.46	4	3
Edmonton West	2,820	9.75	2,510	8.22	- 10.99	3	4
Calgary South West	1,202	4.15	2,351	7.70	95.59	7	5
Edmonton South	2,058	7.11	2,134	6.98	3.69	5	6
Edmonton West 10	1,081	3.74	1,565	5.12	44.77	8	7
Lethbridge	1,447	5.00	1,536	5.03	6.15	6	8
Grande Prairie	958	3.31	1,025	3.35	6.99	9	9
Red Deer	797	2.76	839	2.75	5.27	10	10
Wetaskiwin	709	2.45	743	2.43	4.80	11	11
Medicine Hat	553	1.91	588	1.92	6.33	12	12
High Prairie	493	1.70	489	1.60	- 0.81	13	13
Lac La Biche	399	1.38	438	1.43	9.77	14	14
Barrhead	387	1.34	404	1.32	4.39	15	15
Peace River	329	1.14	360	1.18	9.42	17	16
Vegreville	358	1.24	358	1.17	0	16	17
Bonnyville	303	1.05	334	1.09	10.23	19	18
Slave Lake	321	1.11	327	1.07	1.87	18	19
St. Paul	289	1.00	319	1.04	10.38	20	20
Edson	288	1.00	317	1.04	10.07	21	21
Drumheller	260	0.90	300	0.98	15.38	22	22
Vermillion	247	0.85	266	0.87	7.69	23	23
Smoky Lake	241	0.83	251	0.82	4.15	24	24
Camrose	235	0.81	244	0.80	3.83	26	25
Blairmore	235	0.81	220	0.72	- 6.38	26	26
Athabasca	211	0.73	207	0.68	- 1.90	27	27
Ft. McMurray	171	0.59	196	0.64	14.62	30	28
Wainwright	200	0.69	195	0.64	- 2.50	28	29
High Level	172	0.59	193	0.63	12.21	29	30
Rocky Mtn. House	157	0.64	173	0.57	10.19	32	31
Stettler	163	0.56	164	0.54	0.61	31	32
Olds	141	0.49	155	0.51	9.93	33	33
Whitecourt	126	0.44	153	0.50	21.43	34	34
Brooks	103	0.36	116	0.38	12.62	35	35
Hanna	72	0.25	73	0.25	1.39	36	36
Grande Cache	36	0.12	49	0.16	36.11	37	37
TOTAL	28,931	100.00	30,550	100.00	5.60		

*Adjusted to exclude Guardian Social Allowance cases.

TABLE: 4

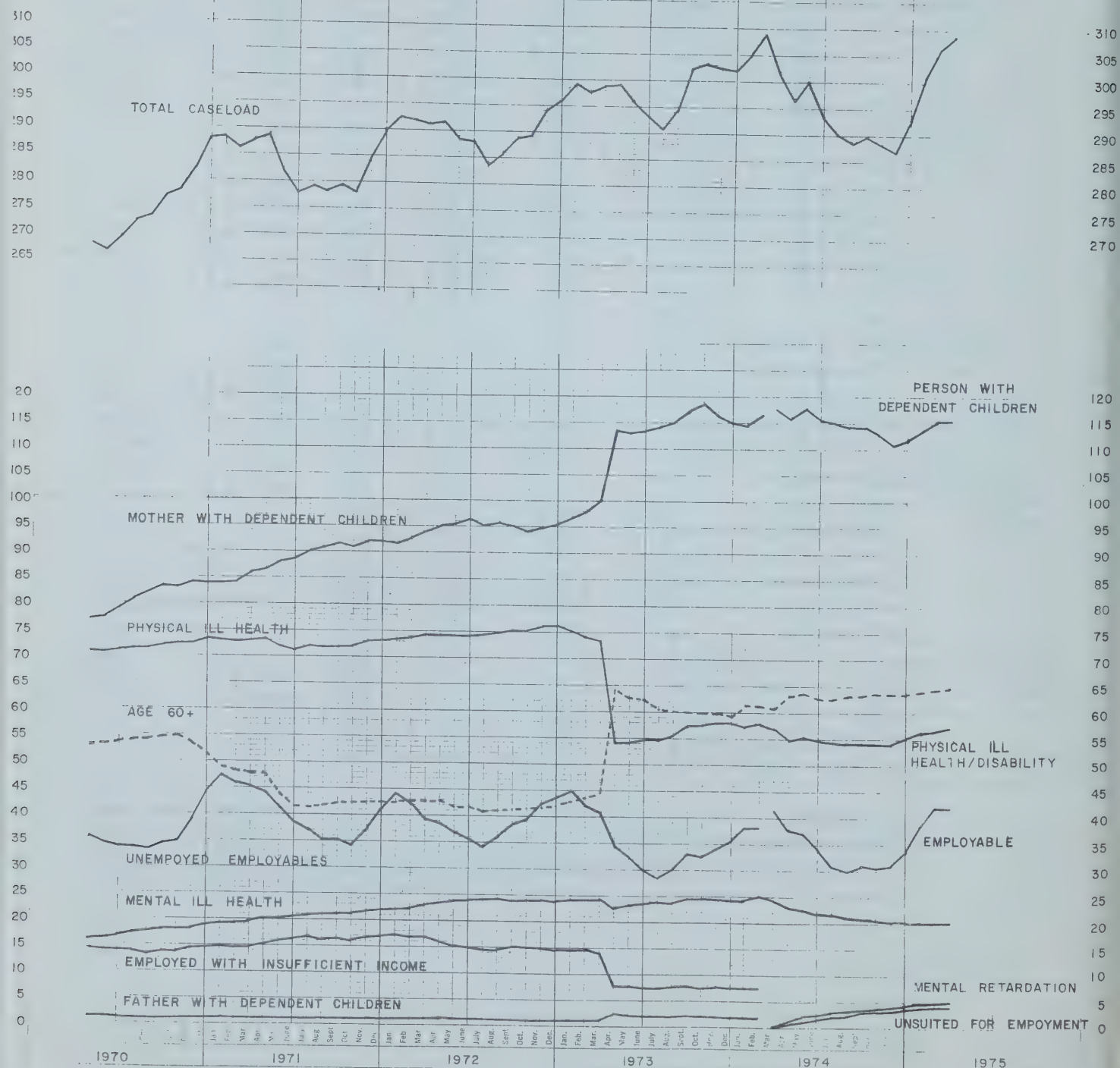
AVERAGE SOCIAL ALLOWANCE CASES BY EMPLOYMENT STATUS AND REASON FOR ASSISTANCE FOR

Quarter: January-March 1975

Employment Status	REASON FOR ASSISTANCE														
	Aged		Persons With Dependent Children		Physical Illness or Disability		Mental Illness		Mental Retardation		Employable		Unsuitable for Employment		Total
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
IN THE LABOUR FORCE															
Employed or in Training:															
Employed and awaiting pay	2	0.03	81	0.72	9	0.16	4	0.20	-		550	13.66			646 2.16
Unemployed	17	0.27	504	4.50	33	0.59	34	1.72	19	3.84	263	6.53			870 2.90
Part-time - not seeking full-time	132	2.09	546	4.88	133	2.40	189	9.54	51	10.30	131	3.25			1,182 3.94
Self-employment	33	0.52	20	0.18	31	0.56	4	0.20	-	-	86	2.14			174 0.58
Attending school up to and including Grade 12	1	0.02	132	1.18	24	0.43	15	0.76	7	1.41	457	11.35			636 2.12
Attending technical or vocational training	1	0.02	341	3.04	33	0.59	13	0.66	-	-	114	2.83			502 1.68
Attending post secondary education	-	-	120	1.07	10	0.18	-	-	-	-	7	0.17			137 0.46
TOTAL	186	2.95	1,744	15.57	273	4.91	259	13.08	77	15.55	1,608	39.93			4,147 13.84
Available for Work:															
Available for full-time work	27	0.43	516	4.61	53	0.95	15	0.76	3	0.61	2,167	53.81			2,781 9.28
Available for part-time work	9	0.14	171	1.53	20	0.36	5	0.25	-	-	43	1.07			248 0.83
Available for sheltered work	-	-	9	0.08	41	0.74	81	4.09	63	12.73	-	-			194 0.65
Seeking part-time; seeking or discouraged to seek full-time	6	0.10	97	0.86	18	0.32	4	0.20	2	0.40	137	3.40			264 0.88
SUBTOTAL	42	0.67	793	7.08	132	2.37	105	5.30	68	13.74	2,347	58.28			3,487 11.64
TOTAL IN THE LABOUR FORCE	228	3.62	2,537	22.65	405	7.28	364	18.38	145	29.29	3,955	98.21			7,634 25.48
NOT IN THE LABOUR FORCE															
Unavailable for Work Due to Illness or Age:															
Illness up to 90 days	25	0.40	81	0.73	680	12.23	79	3.99							865 2.88
Illness 90 days or over	464	7.36	231	2.06	3,854	69.32	1,013	51.16	212	42.83					5,774 19.27
Age	5,407	85.74													5,407 18.04
SUBTOTAL	5,896	93.50	312	2.79	4,534	81.55	1,092	55.15	212	42.83					12,046 40.19
Unavailable to Work Due to Other Reasons:															
Required to care for children	43	0.68	8,260	73.76											8,303 27.71
Expecting a child	2	0.03	27	0.24	169	3.04	1	0.05	1	0.20	65	1.62			265 0.88
In jail less than 90 days	1	0.02									7	0.17			8 0.03
SUBTOTAL	46	0.73	8,287	74.00	169	3.04	1	0.05	1	0.20	72	1.79			8,576 28.62
Unsuitable for Employment	136	2.15	63	0.56	452	8.13	523	26.42	137	27.68	-	-	401	100.00	1,712 5.71
TOTAL NOT IN THE LABOUR FORCE	6,078	96.38	8,662	77.35	5,155	92.72	1,616	81.62	350	70.71	72	1.79	401	100.00	22,334 74.52
TOTAL	6,306	100.00	11,199	100.00	5,560	100.00	1,980	100.00	495	100.00	4,027	100.00	401	100.00	29,968 100.00
Missing data															
	133		197		111		63		1		77				582
Total Caseload by Reason for Assistance															
	6,439		11,396		5,671		2,043		496		4,104		401		30,550

FIGURE 1 PUBLIC ASSISTANCE CASELOAD BY REASON
FOR ASSISTANCE, ALBERTA, APRIL 1970 - MARCH 1975*

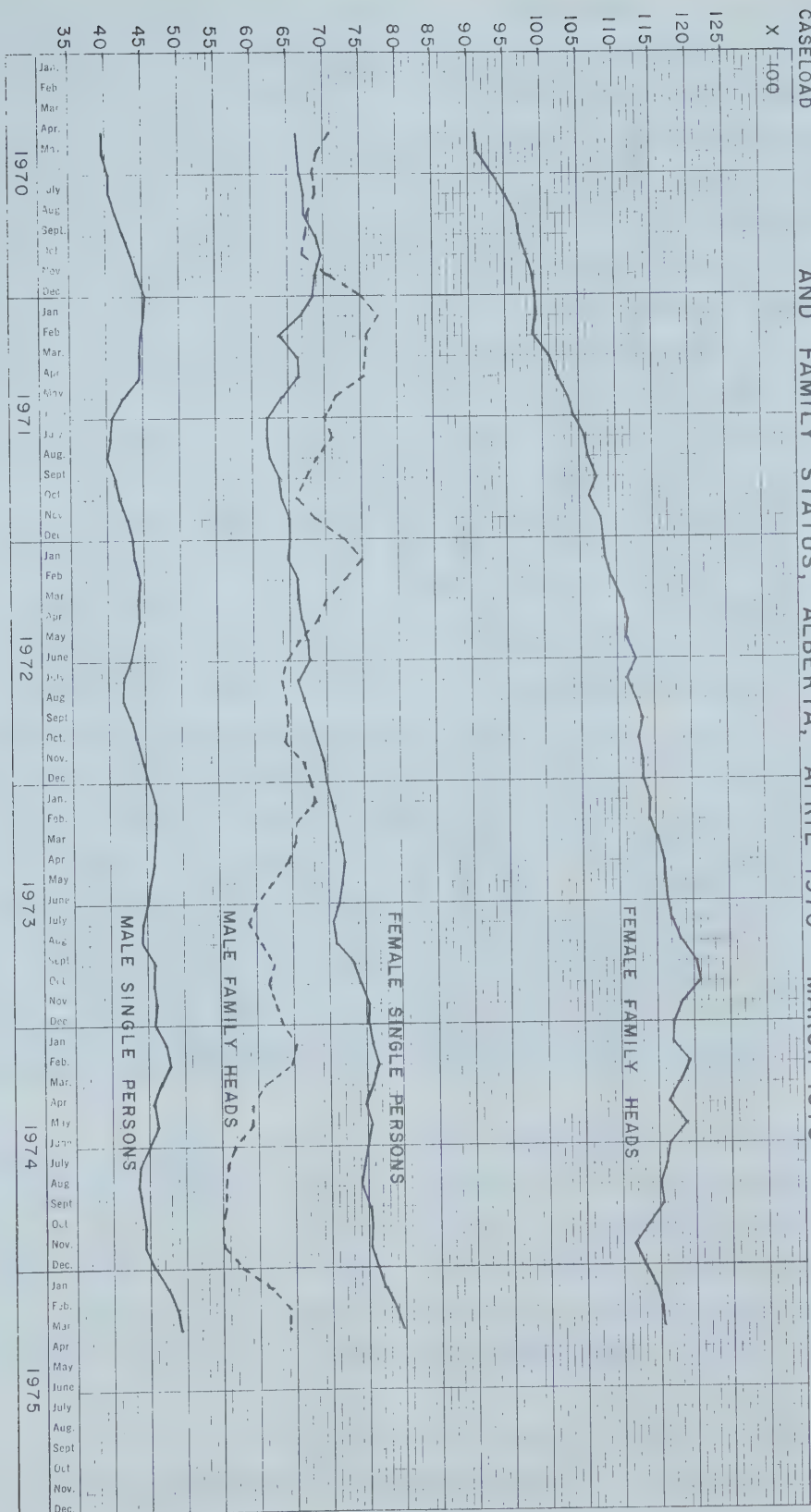
NUMBER OF
CASES X 100



* Major shifts between reasons for assistance in April 1973 result from the change to a priority system of assigning these reasons. Changes in the definitions of reasons for assistance occurring in March 1974 cause a break in the comparability of some caseloads.

CASELOAD

FIGURE 2 PUBLIC ASSISTANCE CASELOAD BY SEX
AND FAMILY STATUS, ALBERTA, APRIL 1970 - MARCH 1975



HIGHLIGHTS OF NOTIFIABLE DISEASES*

Barbara Juchli**

Highlights of the notifiable disease cases for January to March 1975, as reported to the divisions of Local Health Services and Social Hygiene, are presented in the following text and tables. Table 1 shows the geographic distribution of the reported cases, Table 2 illustrates the age-sex distribution, and Tables 3 and 4 compare the number of cases and incidence rates of each disease with the previous five-year corresponding quarter's mean number of cases and rate.

The five most frequently reported notifiable diseases during the January - March quarter were:

streptococcal sore throat and scarlet fever	(2420 cases)
measles	(2411 cases)
gonorrhoea	(1818 cases)
rubella (German measles)	(1530 cases)
infectious hepatitis	(204 cases)

The number of reported cases of streptococcal sore throat and scarlet fever increased by 35.5 per cent over the preceding quarter. Noticeable increases occurred in the City of Red Deer (26 to 115 cases); in the health units of Leduc-Strathcona (49 to 120 cases), Stony Plain - Lac Ste. Anne (107 to 180 cases) and Sturgeon (203 to 309 cases); and on Indian reserves (47 to 124 cases). The total caseload was evenly divided between males and females. The 5-9 year age group had the largest concentration of cases (33.6 per cent). Both the number of cases and the incidence rate for this quarter were over twice the average cases and incidence rate of the five-year corresponding quarter.

Measles more than doubled the number of cases reported in the October - December 1974 quarter. The significant outbreak occurred in the City of Calgary; it reported 55 per cent of the total cases and increased its caseload from 485 in October - December 1974 to 1325 in January - March 1975. The 5-9 year age group contained 49.2 per cent of the total cases; the total caseload was evenly divided between males and females. The number of cases was 4.1 and

* Tuberculosis is not included in this article.

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the incidence rate 3.8 times greater than the preceding five-year figures.

The caseload of reported gonorrhoea decreased 17.3 per cent from the last quarter of 1974; male cases decreased by 12.9 per cent while female cases decreased by 24.5 per cent. The greatest percentage decrease (26.5 per cent) took place in the 15-19 year age group. Comparing the average number of cases and incidence rate for the past five years to this quarter's figures showed a 26.4 per cent increase in male reported cases, 36.9 per cent increase in female reported cases, 18.9 per cent increase in male incidence rate and 28.9 per cent increase in female incidence rate.

Reported cases of rubella have more than tripled (425 to 1530 cases) over the last quarter. Again the City of Calgary showed the largest increase (74 to 440 cases) and had the largest caseload, while the City of Edmonton and the Sturgeon Health Unit increased their caseload by 198 and 100 cases respectively. The 5-9 year age group had 40.2 per cent of the total cases and the total cases were equally divided between the two sexes. The January - March 1975 caseload was 75.6 per cent higher than the mean number of cases for the past five years while the incidence rate was 65.2 per cent higher.

Infectious hepatitis slightly decreased its caseload (3.8 per cent). Smaller numbers of cases were seen in the City of Calgary (43 to 32 cases) and in Indian reserves (45 to 11 cases) whereas larger numbers of cases were seen in the Peace River Health Unit (2 to 19 cases). The majority of cases (63.2 per cent) occurred between the ages of 5 and 24 with the 15-19 year age group accounting for 20.1 per cent of the total caseload. The reported cases were 45.1 per cent lower for January - March 1975 than the five-year mean caseload and the incidence rate was about half the five-year incidence rate.

TABLE 1 REPORTED CASES OF THE MORE FREQUENT NOTIFIABLE DISEASES (EXCLUDING VENEREAL DISEASES)
BY CITY, HEALTH UNIT, OR OTHER JURISDICTION, ALBERTA, JANUARY - MARCH 1975*

Cities	Salmonellosis		Bacillary Dysentery	Diphtheria	Strept. Throat, Scarlet, F.	Pertussis	Infect. Hepatitis	Serum Hepatitis	Measles	Rubella
	Food as vehicle mentioned	Food not mentioned								
Edmonton	1	14	2	-	213	4	39	1	35	275
Calgary	-	11	4	-	62	2	32	5	1,325	440
Grande Prairie	-	-	-	-	24	-	-	-	6	1
Lethbridge	-	-	1	-	8	-	13	-	10	9
Medicine Hat	-	1	-	-	93	-	-	-	3	1
Red Deer	-	-	-	1	115	-	11	-	5	31
Health Units	-	-	-	-	49	-	1	-	3	160
Alberta East Central	-	-	1	-	115	-	10	-	11	104
Athabasca	-	-	1	-	-	-	1	-	-	2
Banff National Park	-	1	-	-	176	-	9	-	146	61
Barons Eureka	-	-	-	-	11	-	-	-	49	2
Big Country	-	-	-	-	40	2	-	-	2	5
Chief Mountain	-	-	-	-	55	-	4	-	87	6
Chinook	-	-	1	-	6	-	-	-	2	2
County of Warner	-	-	-	-	-	-	-	-	38	-
Drumheller	-	-	1	-	114	-	7	-	17	14
Edson	-	-	-	1	8	-	4	-	113	24
Foothills	-	-	23	-	113	-	4	-	2	-
Grande Prairie	-	-	-	-	11	-	1	-	13	9
Jasper National Park	-	-	-	-	120	-	4	-	13	60
Leduc - Strathcona	-	2	1	-	31	-	-	-	6	-
Medicine Hat	4	-	2	-	72	-	-	-	13	1
Minburn - Vermilion	-	-	-	-	13	-	1	-	282	33
Mount View	-	1	-	-	39	-	2	1	1	2
North Eastern Alberta	-	-	7	-	40	-	19	-	37	2
Peace River	-	-	1	-	74	-	4	-	25	28
Red Deer	-	-	-	-	180	-	2	-	13	26
Stony Plain - Lac Ste. Anne	-	1	-	-	309	-	3	-	59	103
Sturgeon	-	2	-	2	79	4	3	1	18	8
Vegreville	-	1	-	-	13	-	5	-	27	113
Wetoka	-	-	-	-	-	-	-	-	-	-
Other Jurisdictions	-	-	-	-	-	-	-	-	-	-
Canadian Forces	-	4	18	4	124	7	11	-	9	-
Indian Reserves	-	1	5	5	111	-	14	-	53	9
Northern Alberta Health Services	-	-	-	-	2	-	-	-	1	1
Other Municipalities	-	-	-	-	-	-	-	-	-	-
TOTAL	5	39	68	13	2,420	19	204	8	2,411	1,530

* There were three cases of Meningococcal infections, two in the city of Calgary and one in the city of Lethbridge. There were four cases of Aseptic meningitis (not specified), one in the city of Calgary, two in the Red Deer Health Unit and one in Northern Alberta Health Services.

TABLE 2 REPORTED CASES OF NOTIFIABLE DISEASES BY SEX AND AGE, ALBERTA, JANUARY - MARCH 1975*

Disease	Under 1		1 - 4		5 - 9		10 - 14		15 - 19		20 - 24		25 - 29		30 - 39		40 - 59		60+		Age not known		TOTAL	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Intestinal Infections																								
Salmonellosis																								
(a) with food as vehicle	-	-	1	-	-	1	-	1	-	-	-	2	2	-	3	1	-	-	1	-	-	-	2	3
(b) without mention of food as vehicle	2	2	4	5	1	2	-	1	1	1	-	2	2	3	3	3	-	1	3	2	-	-	18	21
Bacillary dysentery	4	6	16	28	1	2	2	1	2	1	1	1	1	-	-	-	1	-	1	-	-	-	29	39
Other Bacterial Diseases																								
Diphtheria	-	-	2	5	-	4	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	10
Streptococcal sore throat and Scarlet fever	25	20	224	167	413	399	220	262	121	89	44	59	40	73	74	90	38	40	14	8	-	-	1,213	1,207
Pertussis (Whooping cough)	2	4	3	3	-	6	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5	14
Other Virus Diseases																								
Infectious hepatitis	1	-	4	2	14	17	8	20	17	24	17	12	12	10	8	11	10	10	5	2	-	-	96	108
Serum hepatitis	-	-	-	-	-	-	-	1	1	2	4	7	2	5	4	11	4	1	-	-	-	-	5	3
Measles	38	38	174	178	582	604	349	310	56	44	4	7	9	32	10	24	2	6	-	-	-	-	1,213	1,198
Rubella (German measles)	19	21	80	73	279	336	265	177	75	59	15	48	9	32	10	24	2	6	-	-	-	-	754	776
Gonorrhoea																								
Genito-urinary	-	1	-	1	1	1	2	4	175	224	440	202	256	108	181	55	115	17	6	-	15	14	1,191	627
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Syphilis																								
Congenital	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Acquired																								
(a) Early symptomatic																								
- Primary	-	-	-	-	-	-	-	-	-	1	-	-	-	-	2	-	1	-	-	-	-	-	3	-
- Secondary	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	5	1
- Other and unspecified	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	1	1	4	5	-	-	1	1
(b) Latent	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
(c) Late	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

* There was one case (female) of Typhoid fever in the 20 - 24 year age group. There were three cases of Meningococcal infection, one male less than age 5, one female less than age one, and one female aged 1 - 4 years. There were four cases of Aseptic meningitis (not specified), two females aged 5 - 9, one male aged 15 - 19 and one male aged 30 - 39.

TABLE 3 REPORTED CASES OF NOTIFIABLE DISEASES (EXCLUDING VENEREAL DISEASES, TUBERCULOSIS AND RARE DISEASES) AND INCIDENCE RATES, ABLERIA, JANUARY - MARCH 1975, WITH AVERAGES FOR CORRESPONDING QUARTER 1970 - 1974 *

Disease	January - March 1975		Average for First Quarter 1970 - 74	
	Cases	Incidence Rate per 100,000	Cases	Incidence Rate per 100,000
Intestinal Infections				
Salmonellosis	5	0.29	6.20	0.38
(a) with food as a vehicle	39	2.23	87.60	5.33
(b) without mention of food as vehicle	68	3.89	74.80	4.55
Bacillary dysentery				
Other Bacterial Diseases	13	0.74	18.00	1.09
Diphtheria				
Streptococcal sore throat and scarlet fever	2,420	138.52	1,116.60	67.92
Pertussis (Whooping cough)	19	1.09	20.00	1.22
Other Virus Diseases				
Infectious hepatitis	204	11.68	371.40	22.59
Serum hepatitis	8	0.46	11.20	0.68
Measles	2,411	138.01	591.80	36.00
Rubella (German measles)	1,530	87.58	871.40	53.00

*Population figures for incidence rates are from Statistics Canada's quarterly estimates - Catalogue 91-001, January 1975.

TABLE 4 REPORTED CASES OF VENEREAL DISEASES AND INCIDENCE RATES BY SEX, ALBERTA,
JANUARY - MARCH 1975, WITH AVERAGES FOR CORRESPONDING QUARTER 1970 - 1974*

	January - March 1975				Average for First Quarter 1970 - 74			
	Cases		Incidence Rate per 100,000		Cases		Incidence Rate per 100,000	
	Male	Female	Male	Female	Male	Female	Male	Female
Gonorrhoea								
Genito-urinary	1,191	627	134.35	72.86	942.60	458.00	113.02	56.54
Other	-	-	-	-	-	-	-	-
Syphilis								
Congenital	-	-	-	-	1.00	0.20	0.12	0.02
Acquired								
(a) Early symptomatic	3	-	0.34	-	4.80	0.40	0.58	0.05
- Primary	5	1	0.56	0.12	7.00	2.60	0.84	0.32
- Secondary	1	1	0.11	0.12	1.60	1.00	0.19	0.12
- Other and unspecified	14	12	1.58	1.39	10.40	10.00	1.25	1.23
(b) Latent	-	-	-	-	0.20	0.20	0.02	0.02
(c) Late	-	-	-	-	-	-	-	-

*Population figures for incidence rates are from Statistics Canada's quarterly estimates - catalogue 91-001, January 1975.
The 1971 Alberta sex ratio was used to calculate male/female populations.

GLOSSARY

- Age-sex pyramid - a graphic technique for illustrating the age-sex composition of a population. Each bar on the pyramid usually represents the percentage of the population falling into a 5 or 10 year interval, with males to the left of center, females to the right.
- Aging of the population - a term commonly used to refer to the phenomenon of an increase in the proportion of a given population falling within the age category of 65 years and over.
- Alberta Assured Income Plan (AAIP) - provincial program which provides payments to those persons who are in receipt of Old Age Security and Guaranteed Income Supplement payments and who are aged 65 or older.
- Auxiliary hospital - in Alberta, a facility which provides skilled nursing care and medical monitoring for terminally ill, permanently disabled, short-stay convalescent, and long-term rehabilitation patients.
- Baby Boom - a period of high fertility in North America lasting from approximately 1945-1960.
- Caseload - the number of households, or units, assisted; these units consisting of one or more persons. Caseload is often used to refer to the collective heads of these units.
- Dependency ratio - the ratio of the number of dependent persons (0-14 years and/or 65+ years) per 100 persons of productive age (15-64 years).
- Eugenic - concerned with the preservation of desirable hereditary qualities in offspring.
- Geriatrics - a branch of medicine that deals with the problems and diseases of old age and aging people. Compare with gerontology.
- Gerontology - a broad term referring to a branch of knowledge dealing with aging and the problems of the aged. Compare with geriatrics.
- Guaranteed Income Supplement (GIS) - federal payment under the Old Age Security Act which may be added to the basic Old Age Security pension in the case of pensioners who have no other income or only a limited amount.
- Guardian Social Allowance (an extension of the social allowance program) - an allowance for basic necessities provided by the department, in the absence of the parent(s), to a person who in the opinion of the director is properly caring for the child.
- Homes for special care - in Alberta, a facility which provides room and board and varying levels of care and/or supervision.
- Labor force participation rate - the percentage of the total population in a defined group included in the labor market. Refer to footnote "b" on Table 9 of "Older People in Alberta" for a more detailed definition.
- Life expectancy - the average number of years an individual with certain characteristics (e.g., sex, present age, occupation) can expect to live. The statistics are based on actual mortality experience of cohorts of persons sharing such characteristics.
- Municipal Caseload - a municipality is responsible for assisting an employable person who is a resident of the municipality and
- (1) was a resident of the municipality during the twelve months immediately preceding his application, and
 - (2) did not, during any part of these twelve months, receive material aid from the province or any other municipality.
- The municipality is reimbursed 90 per cent by the province for expenditures incurred.

Nursing home - in Alberta, a facility which provides personal care with nursing supervision.

Old Age Security (OAS) - federal program which provides payment of a basic pension to everyone who has reached age 65 and has fulfilled the residence requirements.

Reasons for Assistance - The social allowance program is available to those persons who lack the resources of income sufficient to meet their needs and those of their dependents. Eligibility for assistance was defined within the following categories until March 1974; for each application, the social worker assigns a reason for assistance on the following rank order basis. Since April 1973, applicants were assigned to the first category of reason for assistance that applied to them, proceeding through the list of reasons in their specified order.

1. Age (Person 60 or over) - A person may be considered eligible for assistance under this reason if 60 years of age or older. Prior to November 1971, women between 55 and 60 years of age were also eligible for Social Allowance by reason of age alone.
2. Mother with Dependent Child(ren) - This reason is applicable to the single female parented family where the parent actually has custody of or is personally caring for a dependent child.
3. Father with Dependent Child(ren) - This reason is applicable to the single male parented family as in 2 above.
4. Physical Ill Health - This reason is applicable to a person with a physical disability, impairment, or illness, regardless of expected duration, which prevents rendering services for wages sufficient to meet the person's needs and those of dependents.
5. Mental Ill Health - This reason is applicable to persons having an obvious mental illness or a medical certificate confirming such mental illness, regardless of the expected duration.
6. Employed with Insufficient Income - Persons employed full-or part-time with insufficient income.
7. Unemployed Employables - This reason is applicable to persons who are unemployed and seeking employment or whose employability may be under assessment. This reason also applies to persons temporarily unavailable for work because of schooling, pregnancy, or in jail for less than 90 days.
8. Guardian Social Allowance - This is an extension of the Social Allowance program designed to assist persons acting as guardians and providing care to children placed in their homes by parents unable or unwilling to provide such care.

Changes in Reasons for Assistance introduced in March 1974 follow a similar rank ordering.

1. Age (Person 60 or over) - As defined above in 1.
2. Person with Dependent Child(ren) - As defined in 2 and 3 above, for single parents of either sex.
3. Physical Ill Health/Disability - As defined in 4 above.

4. Mental Ill Health - As defined in 5 above, excluding mental retardation.
5. Mental Retardation - This reason is applicable to persons who are mentally retarded. A medical certificate or assessment is required if the disability is not readily recognizable.
6. Employables - As defined in 6 and 7 above.
7. Unsuitable for Employment - This reason is applicable to cases which have been assessed as socially, psychologically, or otherwise unsuited for employment. Such cases would be transferred from other reasons for assistance after an assessment period.
8. Guardian Social Allowance - As defined in 8 above.

Recipients - In contrast to the term "caseload", this term refers to the unit heads plus their dependents. The number of recipients on assistance is approximately two or three times as great as the caseload.

Rural non-farm - population centers of less than 1000 persons.

Sex-ratio - the number of males per 1000 females in a population.

Type of care (nursing homes) - please refer to the footnote on Table 20 of "Older People in Alberta" for a full definition.

WHO - World Health Organization

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